National Library
of Canada

Canadian Theses Service

Ottawa, Canada
K1A 0N4

Bibliothèque nationale
du Canada

Services des thèses canadiennes

CANADIAN THESES

THÈSES CANADIENNES

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

THIS DISSERTATION
HAS BEEN MICROFILMED
EXACTLY AS RECEIVED

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

LA THÈSE A ÉTÉ
MICROFILMÉE TELLE QUE
NOUS L'AVONS REÇUE

NL-339 (r. 86/01)

Canada

293

0-315-27024-1

National Library of Canada
Canadian Theses Division
Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada
Division des thèses canadiennes

PERMISSION TO MICROFILM — AUTORISATION DE MICROFILMER

• Please print or type — Écrire en lettres moulées ou dactylographier

Full Name of Author — Nom complet de l'auteur: MARY EVELYN MOLYNEUX

Date of Birth — Date de naissance: SEPT. 17, 1957

Country of Birth — Lieu de naissance: CANADA

Permanent Address — Résidence fixe:
38 WEDGEWOOD DR. SW
Calgary Alta
T3C 3G5

Title of Thesis — Titre de la thèse: COPING WITH STRESS: AN EXPLORATORY LOOK AT ONCOLOGY NURSES.

University — Université: UNIVERSITY OF ALBERTA

Degree for which thesis was presented — Grade pour lequel cette thèse fut présentée: MASTER OF EDUCATION

Year this degree conferred — Année d'obtention de ce grade: 1983

Name of Supervisor — Nom du directeur de thèse: DR. RONNA JEVNE

Permission is hereby granted to the NATIONAL LIBRARY OF CANADA to microfilm this thesis and to lend or sell copies of the film.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

L'autorisation est, par la présente, accordée à la BIBLIOTHÈQUE NATIONALE DU CANADA de microfilmer cette thèse et de prêter ou de vendre des exemplaires du film.

L'auteur se réserve les autres droits de publication; ni la thèse ni de longs extraits de celle-ci ne doivent être imprimés ou autrement reproduits sans l'autorisation écrite de l'auteur.

Date: May 31, 1983

Signature: Mary E. Molyneux

NL-91 (4/77)

THE UNIVERSITY OF ALBERTA

COPING WITH STRESS: AN EXPLORATORY LOOK AT ONCOLOGY NURSES

by

© MARY EVELYN MOLYNEUX

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF EDUCATION
IN
COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1983

MICRO

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR Mary Evelyn Molyneux

TITLE OF THESIS Coping With Stress: An Exploratory Look at Oncology Nurses

DEGREE FOR WHICH THESIS WAS PRESENTED Master of Education

YEAR THIS DEGREE GRANTED 1983

Permission is hereby granted to THE UNIVERSITY OF ALBERTA LIBRARY to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

(Signed) Mary Molyneux

PERMANENT ADDRESS:

303, 5314 Riverbend Rd.
EDMONTON, Alberta
T6H 4Z4

DATED May 30, 1983

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Coping With Stress: An Exploratory Look at Oncology Nurses," submitted by Mary Evelyn Molyneux in partial fulfilment of the requirements for the degree of Master of Education.

R.F. Jevne
Supervisor

D.D. [illegible]

Rhea Arsand

Date April 26, 1983

To Ian,

for his love, support, patience and humour.

And to my family,

for their love, help and understanding over the years.

ABSTRACT

There is consensus that we all experience stress in our lives; the research on how we cope with stress is in the early stages of development. How people cope is felt to be more important to overall morale, social functioning and somatic health than the frequency of and severity of the stressors themselves (Roskies and Lazarus, 1979). The purpose of this study was to identify the coping strategies, coping resources and coping effectiveness with stress of nurses working in an oncology setting, with the intention of developing groundwork for research more empirical in nature (in the area of coping with stress) and of helping the population from which the subjects were drawn.

Fourteen ward nurses from the W.W. Cross Cancer Institute, Edmonton were selected for in-depth semi-structured interviews. Their selection was based upon their willingness to participate and the demographic variables of: whether employed full time or part time; length of time as a nurse; and length of time as a nurse in that setting. The semi-structured interview was designed to elicit information regarding: coping strategies; coping resources; factors that may block or help the individual when coping with stress; and coping effectiveness. The demographic variables were used to determine if there were any demographic differences in the subjects' styles of coping.

The results of the study were descriptive rather than statistical in nature. The importance of support for the subjects, particularly from nursing peers, when coping with stress emerged as a very important theme in the strategies and resources used and the resultant effectiveness. A wide variety of coping strategies and resources were used, resulting in generally good overall "felt" effectiveness; this supported those strategies and resources identified in the literature and the need for a repertoire of strategies and resources when coping with stress. Awareness of areas where there was difficulty in coping with stress seemed to promote a desire for more information and ideas to ease these difficulties. Due to the small sample size, it was difficult to determine any demographic differences.

Implications for the setting and sample were discussed, as were implications for other helping professionals in the oncology setting and areas for further research.

ACKNOWLEDGEMENTS

I would like to thank the many people who have been involved with and have contributed to this thesis.

Dr. R. Jevne, thesis supervisor, for her ideas, enthusiasm and encouragement throughout the thesis. Dr. D. Sawatzky and Mrs. R. Arcand, the members of the thesis committee, for their feedback, interest and assistance.

Mary James, the Director of Nursing at the W.W. Cross Cancer Institute, Edmonton, for her invaluable help and ideas. The senior nursing staff who helped with the development of the stories used in the interviews.

And finally, to the participants in this study, my appreciation for their willingness to give of their time and share their thoughts and feelings so freely.

TABLE OF CONTENTS

Chapter page

I INTRODUCTION 1

Introduction to the Study 1

Research Questions 2

General Research Question 2

Specific Questions 2

II REVIEW OF THE LITERATURE 3

Stress 3

Stress Encountered by Nurses in an Oncology Setting..... 6

Coping 9

Definition of Coping and its relationship to stress 9

The coping process 10

Coping strategies 16

Classification of coping strategies 20

Coping resources 29

Coping effectiveness 32

III METHODOLOGY 35

General Purpose of Research 35

The Setting 35

Chapter page

Sample 36

Procedure 37

  Pilot study 37

Instrumentation 40

  The interview schedule 43

Analysis of Data 44

Limitations 45

IV RESULTS 47

Case Descriptions 48

  Subject A 48

  Subject B 51

  Subject C 57

  Subject D 62

  Subject E 66

  Subject F 71

  Subject G 74

  Subject H 79

  Subject J 84

  Subject K 89

  Subject L 91

  Subject M 96

  Subject N 100

  Subject O 104

Chapter page

V DISCUSSION AND CONCLUSIONS 109

Overview 109

Discussion 110

What coping strategies are used? 110

What coping resources are used? 118

How effective do the nurses consider their coping strategies to be? 121

What may be blocking the individual from coping effectively with job related stress? 124

What may help the individual to cope more effectively with job related stress? 125

Demographic differences 127

Perceptions of coping with stress 128

Conclusion 129

Implications and Recommendations for the Setting and the Sample 130

Implications for Helping Professionals Working in an Oncology Setting 134

Implications for Further Research 135

Delimitations 137

SELECTED REFERENCES 139

APPENDICES: A PRESENTATION TO THE NURSES 144

B INFORMATION SHEET 147

C STRESSFUL INCIDENTS GENERATED 149

D LIST OF COPING STRATEGIES 156

E INTERVIEW FORMAT 159

LIST OF TABLES

Table	Description	page
1	Coping Classification Scheme	26
2	Demographic Variables	38
3	Use of Coping Strategies	108

LIST OF FIGURE

Figure page

1 Primary and Secondary Appraisal 14

CHAPTER I

INTRODUCTION

Introduction to the Study

There has been considerable research into the area of stress and although there is consensus that we all experience stress in our lives, there is as yet comparatively little research on how we cope with stress. How people cope is felt to be more important to overall morale, social functioning and somatic health than the frequency of and severity of the stressors themselves (Roskies and Lazarus, 1979). There is a lack of information as to how a non-clinical population deals with different stressors over time (Roskies and Lazarus, 1979). Roskies and Lazarus (1979) identified three areas that need to be addressed in the study of coping:

1.) development of a system of describing, measuring and evaluating coping;

2.) research into how coping strategies develop, especially effective and ineffective patterns and how they change;

3.) development of treatment paradigms that recognize the importance of individual differences in such things as belief systems, values, styles of thinking and living, etc.

This study will address the first area described above in relationship to the stress encountered by nurses working in an oncology setting and how they cope. It is hoped that by identifying the nurses' coping strategies, coping resources and coping effectiveness with stress, that this study will: lay some groundwork for research more empirical in nature; and help the population from which the nurses are drawn in coping with their job related stress.

Research Questions

General Research Question

How do the nurses cope with stress encountered in an oncology setting?

Specific Questions

1. What coping strategies are used?
2. What coping resources are used?
3. How effective do the nurses consider their coping strategies to be?
4. What blocks the nurses from coping better with job related stress? What do they feel would help them to cope better?
5. What differences, if any, are due to the demographic variables of: working full time vs. part time; length of time as a nurse; and length of experience as a ward nurse in an oncology setting?

CHAPTER II

REVIEW OF THE LITERATURE

Given this study focuses on how oncology nurses cope with stress, the relevant background important to this review includes: general concepts related to stress; information specific to the stress of oncology nurses; and an understanding of coping, including the coping process, strategies, classification systems, resources and factors related to effectiveness.

Stress

It is important to this study to have a basic understanding of psychological stress, in order that the importance of coping may be better understood. In this section, three variations of the definition of stress will be discussed, psychological stress will be differentiated from other types of stress and the concept of stress felt to best relate to coping will be identified.

In the early part of this century, stress was defined as "threatening psychosocial demands upon the individual" (Mason, 1975, p. 22). Stress was also seen as equivalent to trauma or catastrophe (Jacobson, 1976). Since the time of these conceptions of stress, the definition has undergone many changes. Three variations of the concept have developed.

The first defines stress as a stimulus, a force acting upon the individual (Mason, 1975; Lazarus and Launier, 1978). This idea is particularly popular in the physiological studies of stress and is found in much of the early stress literature. However, this definition does not take into account individual differences which may affect stress, such as an individual's past history, personality factors, ability to appraise the situation and ability to cope (Mason, 1975).

Selye introduced the second variation: the idea of stress as a response, "the non-specific response of the body to any demand made upon it" (Mason, 1975, p. 28). Along these lines, Appley and Trumbull (1967) also note that the presence of emotional activity, a type of response, has been used to define the existence of stress. The difficulty of defining stress as only a response is that no universal or totally nonspecific responses have been demonstrated (Mason, 1975). Also, responses have been found to change over time with continued exposure to a stressful situation (habituation) (Mason, 1975).

The third concept of stress is that of a stimulus-response interaction. Within this concept, there appear to be two possibilities. The first is a linear S-R model (Mason, 1975); with this, there is again the problem with developing "... a set of response criteria sufficiently operational and comprehensive without being hopelessly complicated" (Mason, 1975, p. 33). The second possibility seems to be one with a great deal of support within the literature (Lazarus, 1966; Mason, 1975; Appley and Trumbull, 1967; Jacobson, 1976; Lazarus and Launier, 1978). The stimulus-response interaction becomes a transaction, "... describing certain kinds of adaptive commerce between any system (e.g. a person) and an environment" (Lazarus and Launier, 1978, p. 293), with stress as:

> ... any event in which environmental or internal demands (or both) tax or exceed the adaptive resources of an individual, social or tissue system. (Lazarus and Launier, 1978, p. 296)

The model is not linear as it demands a "reciprocity of causation" (Lazarus and Launier, 1978, p. 291). This means there is feedback to the individual from his/her response to the stimulus, which impacts the individual's appraisal of the situation; this may lead to another response or a resolution of the stress. The cognitive component is very important to this concept of stress.

Antonovsky (1979) defined stress similarly: the external or internal demands (the stressor) upset the organism's homeostasis, but this stressor also depends upon the meaning the person attributes to the stimulus and the individual's available response repertoire. Meaning is the intervening variable that can change the individual's response, which is also supported by Katz et al (1971).

One further classification regarding stress needs to be made. Stress can be considered psychologically, physically and biochemically. Psychological stress is the stress explored in relationship to the nurses in this sample; measurement of physical or biochemical stress and how it is coped with is beyond the scope of this study. Psychological stress

> ... differs from other types of stress by the intervening variable of threat, cirsumstances in which the person anticipates some harmful condition... (Jacobson, 1976, p. 35)

and evokes negative emotional affect, such as fear, anger, guilt, anxiety, depression, etc.

The concept of stress is not without its difficulties when it comes to research. As a transaction involving many factors, stress becomes a somewhat abstract concept (Mason, 1975). Lazarus' (1966) definition illustrates the problem:

> "Stress" is a generic term for a whole area of problems that include stimuli producing stress reactions, the reactions themselves, and various intervening processes. (p. 27)

Because of this, Lazarus contends it is important for the researcher to clarify the perspective of stress under consideration, whatever his/her bias (Mason, 1975). In recognition of this concern and for the purposes of this study, stress will be considered a transaction. This definition seems to best relate to the area of coping. Prior to discussing the relationship of stress and coping, a brief review of the research on stresses encountered by oncology nurses is presented as a backdrop to the study setting.

Stress Encountered by Nurses in an Oncology Setting

Hartl (1979) represented stress for nurses generally as follows:

	On the job	Away from work
Recent events	new doctor, new policies, more work, reorganization, etc.	death in family, marriage, accidents, new residence, etc.
Ongoing conditions	medical hierarchy, patient care, too few resources, etc.	unusual hours at home, cost of living, family problems, etc.

(p. 93)

The stresses encountered away from work will not be considered in this study. Although it is recognized that non-work related stress impacts the individual, it is beyond the scope of this study to consider how the nurses cope with these stresses and their relationship to work effectiveness. These are stresses that all nurses encounter, but there are also stresses found to be specific to the oncology and related settings, such as palliative care units and hospices. Dealing with the terminally ill can adversely affect the nurse and can be affected by attitudes, values and personal agendas.

In an exploratory study, Arcand (1980) identified five main sources of stress for nursing staff working at the W.W. Cross Cancer

Institute, Edmonton: 1.) death/loss of a patient; 2.) dying and suffering of a patient; 3.) job ambiguity; 4.) communication with the patient, physicians, the families and the team; and 5.) critical physician feedback.

The results of Arcand's (1980) study are echoed in various ways by other researchers. Patrick (1981) found that, due to the complex nature of cancer and its various forms, the work environment taxes the oncology nurse's resources and knowledge. The stressfulness of this 'drain' is compounded by: the technological advances; helping by hurting (e.g. giving drugs that may have adverse side effects); confronting death; grieving families; staff conflict; and personally held values and attitudes. The results of Vachon (1978), that nurses working in a hospice setting are at risk due to the stress, are generalizable to nurses in an oncology setting. Beszterczey (1977), who discussed internal and external stressors, identified specific stressors for palliative care nurses. Externally induced stressors included: the serious nature of the disease process; distraught relatives; greater responsibility; and the sights and sounds encountered. Internal pressures came from: trying to resolve the poorly defined expectations imposed by patients, families, doctors, other nurses and hospital administration; the burden of frequent deaths; feelings of inadequacy (not being able to do more for the patient and the family); guilt and overinvolvement; and dealing with unresolved personal losses.

Numerous studies attempted to isolate the personality and intrapsychic factors involved. Often the stress of dealing with the terminally ill leads to avoidance of the patient and more focus by the nurse on the mechanistic and clerical aspects of patient care (Gluck, 1977; Gow and Williams, 1977; Folta, 1963; Michaels, 1971; Lazarus, 1975). In exploring the intrapsychic dynamics, the dying patient can represent to the nurse her own mortality, causing her great anxiety (Folta, 1963; Stoller, 1980; Davitz and Davitz, 1975), as well as conflict with the ideal of saving lives (Quint, 1966). Work experience with the dying has not been found to help the nurses deal with the resultant stress (Stoller, 1980; Lester, Getty and Kneisl, 1974).

Other factors, such as attitudes and values, often affect the stress encountered by nurses. In addition to the ideal of saving lives mentioned earlier, nurses have been found to hold the value of giving unselfish service or care to others (Hartl, 1979). If this causes a nurse to ignore her own wants and needs, she "... virtually guarantee[s] [herself] an inappropriately high level of stress as an ongoing condition of life" (Hartl, 1979). Vachon (1978) found that hidden personal agendas of nurses can lead to considerable stress (perhaps due to too high expectations, unresolved grief, etc.) and that this stress could be avoided if the nurses learn to deal with the issues in these agendas.

Also, nurses tend to have barriers to seeking support, as if they do not have the right to feel anger, sadness, anxiety or despair (Michaels, 1971). Support can be important in helping an individual deal with stress; if support cannot be utilized, this can make stress all the more difficult to deal with.

The sources of stress Arcand (1980) derived from the nurses at the Cross Cancer Institute will be utilized in the attempt to discover how nurses in an oncology setting cope with stress, and the strategies and resources they use. These stressors are a logical choice since they were derived from the same setting as the sample under study and are consistent with the stressors identified in the literature.

Prior to finding out how the sample cope with stress, the resources they use and how effectively they feel they cope, it is necessary to define coping and to understand the relationship between stress and coping. A discussion of coping strategies, process, classification systems, resources and effectiveness will be included.

Coping

No agreed upon theory of coping exists (Lazarus and Launier, 1978); this leads to ambiguity as to what is or is not coping. Due to the relatively recent focus on this area, studies into the psychology of coping are largely descriptive in nature, rather than systematic and predictive (Lazarus, 1975).

Definition of coping and its relationship to stress

> ... coping can never be assessed without regard to the environmental demands that create a need for it in the first place nor without reference to the person who is responding to it ...
> (Lazarus, Averill and Opton, 1974, p. 302)

Defining coping is a necessary but difficult task due to its relationship with stress. Coping must be discussed in the context of stress:

> Coping is a reaction to stress, but also a shaper of the stress experience ... Coping and stress are but two faces of the same coin and any model of stress must also be viewed as a model of coping. (Roskies and Lazarus, 1979, p. 45)

Stress is what is happening to the person; coping is what the person does about it.

Numerous definitional attempts have been made (White, 1974; Lazarus, Averill and Opton, 1974; Folkman et al, 1979; Roskies and Lazarus, 1979). One of the most comprehensive and clear definitions available and the one that shall be used in this study was proposed by Lazarus and Launier (1978):

> Coping consists of efforts, both action-oriented and intrapsychic, to manage (i.e. master, tolerate, reduce, minimize) environmental demands and conflicts among them, which tax or exceed a person's resources. Reference to taxing or exceeding resources place coping within the rubric of psychological stress ... (pp. 310-311)

It is important to focus more clearly on what coping is; to do this, it needs to be distinguished from adaptation. Lazarus and Launier (1978) clarify the difference:

> Virtually everything we do has adaptive significance... A few writers, like ourselves, have attempted to narrow the meaning sphere of coping by distinguishing coping from adaptation ... The main distinction drawn seems to be a matter of whether or not the person has a well-established or automatic response readily available (as when we step on the brake when a traffic light turns red) as opposed to being in a situation for which the adequate response is unclear, unavailable, difficult to mobilize or its adequacy doubtful. (p. 310)

Coping is a response to a stressful situation, whereas adaptation is a response in any situation that has adaptive significance; coping is therefore a subset of adaptation. As a subset, coping has a narrower focus than adaptation (Lazarus and Launier, 1978).

The definition of coping used in this study indicates that coping is involved in many levels in the individual (behavioral, cognitive and perceptual). Because of its transactional nature, coping is a process (Roskies and Lazarus, 1979).

The coping process

The process of coping depends on a transaction involving the individual's personality (including beliefs, expectations, etc.), the nature of the environmental demands, the available resources and how all of this is appraised by the individual (Lazarus, 1975; Monat and Lazarus, 1977; Roskies and Lazarus, 1979; Lazarus and Launier, 1978). No one personality type, stimulus or reaction is sufficient to understanding coping (Roskies and Lazarus, 1979).

Lazarus and his numerous associates seem to have the most comprehensive description and analysis of the coping process. One important component of this theory is the concept of cognitive appraisal, which can be understood as:

> ... the mental process of placing any event in one of a series of evaluative categories related either to its significance for the person's well-being (primary appraisal) or to the available coping resources and options (secondary appraisal).
> (Lazarus and Launier, 1978, p. 302)

Secondary appraisal, most important to this review of coping, is influenced by primary appraisal, therefore a discussion of both is required.

Primary appraisal is how the individual assesses the impact of an event on his/her well-being: i.e. is an event going to be stressful or not in this particular situation? There are three categories of primary appraisal: 1.) irrelevant; 2.) benign positive; and 3.) harmful (Lazarus and Launier, 1978). An irrelevant appraisal indicates that there is no implication on the individual's well-being at the time. A benign positive appraisal signifies a positive state of affairs. A harmful appraisal indicates some harmful implication to the individual's well-being.

For the purpose of simplicity, the scope of psychological stress under consideration will be that which leads to negatively toned emotions such as fear, guilt, sadness, anger, etc. Positively toned emotions may lead to stress, when there is a benign positive appraisal, but it is the influence of the harmful appraisal that is being considered in this study.

Within the harm category of appraisal, there are three finer distinctions, each involving a negative evaluation of the individual's current or future state of well-being (Lazarus and Launier, 1978). The first is harm-loss, which means the damage has already occurred. The second is threat, which indicates that the harm or loss has not yet occurred, but is anticipated. The third is challenge, which differs from threat, as it emphasizes mastery or gain (which may be difficult to obtain and may be risky) rather than emphasizing the potential harm. When a situation is appraised as a challenge, it is not clear how much of the appraised challenge may actually be denial of circumstances, etc., causing the individual to deal with the situation as a challenge rather than a threat. It is important to remember that appraisal depends upon the events and the person's beliefs, expectations, ideals and values.

Primary appraisal differs from secondary appraisal in what is being assessed. Primary appraisal asks "what is happening?"; secondary appraisal asks "what can I do about it?" (see Figure 1). Secondary appraisal assesses the individual's coping resources and options. Though called secondary appraisal, this does not mean that it follows primary appraisal temporally nor is it less important (Lazarus and Launier, 1978). It is believed that:

> ... cognitions about coping options and resources can arise and be stored in memory well before the primary appraisal of threat or harm-loss occur. (Lazarus and Launier, 1978, p. 305)

PRIMARY APPRAISAL ---------------interaction--------------- SECONDARY APPRAISAL

"what is happening?"

Types of primary appraisal
    1.) irrelevant
    2.) benign positive
    3.) harmful: a.) harm-loss
                  b.) threat
                  c.) challenge

"what can I do about it?"

Influences on secondary appraisal
    1.) location of threat
            a.) external
            b.) internal
    2.) choice and viability of available coping strategies
    3.) type of situation
    4.) personality factors

Figure 1. Primary and Secondary Appraisal

These two forms of appraisal interact with each other, each being able to influence the process of the other. These appraisal processes may also be unconscious or deliberate.

Primary appraisal impacts secondary appraisal, secondary appraisal impacts primary appraisal; stress impacts coping, coping impacts stress. The feedback that appraisals get from the individual's information and reactions and from reactions in the environment lead to another appraisal process, reappraisal. Reappraisal is a change in the original perception or "... a response to a cue to changing internal or external conditions" (Lazarus, Averill and Opton, 1974, p. 260). For example, reappraisal can change something from being regarded as benign positive to a threat and can be defensive in nature.

Stress theory emphasizes cognitive appraisal and coping as a process (Roskies and Lazarus, 1979), therefore:

> the appraisal of excessive demands ... is equally the appraisal of inadequate resources. Beliefs about one's capacity to cope relate back to one's original appraisal of stress and constantly affect the flow of cognitive and emotional activity. (Roskies and Lazarus, 1979, p. 45)

The concept of secondary appraisal is needed to explain the various coping strategies, threat and stress reactions, and the influence of these variations on the stimuli and the personality. Three factors are important in determining the secondary appraisal process and the coping strategies chosen (Lazarus, 1966). The first is the location of the threat. If the threat is identifiable, direct forms of coping may be chosen. People feel less helpless when they are able to direct their strategies against something tangible; blaming can play a large part in helping people cope. When threat is internal, it is usually dealt with intrapsychically, e.g. defense mechanisms, since there is nothing external at which to direct action. Another factor is the choice of available coping strategies and the viability of those strategies (Lazarus, 1966). Coping strategies will be discussed in detail later on in this review. The third factor is the type of situation in which the stress occurs, as a situation can put certain restraints upon coping responses (Lazarus, 1966). Social norms and pressures may impose upon the coping response (Lazarus, 1966) and must be considered when evaluating coping (Lazarus, Averill and Opton, 1974).

Personality factors, not mentioned by Lazarus (1966), may also affect how an individual appraises a situation and copes. Hamburg, Coelho and Adams (1974) state that some personality dispositions may contribute to specific coping patterns because of the individual's orientation to the stimulus object; the coping strategy chosen depends on how the individual defines the situation, which relates to the notion of appraisal discussed earlier.

Within the 'movement' of the coping process are stable factors; for example, often the person remains within the same environment over time and also has stable tendencies they carry with them (beliefs, commitments, and coping styles). Stable factors are important as they may cause an individual to appraise certain events in similar ways (Lazarus and Launier, 1978). However, stability is only a limited part of the coping process, as change is needed for effective adaptation; variability allows for growth, using different responses for similar situations may increase one's response repertoire and that which seems stable may not be - change must be considered along with stability (Lazarus and Launier, 1978).

In summary, coping is a process which changes as a result of new information and previous outcomes. Appraisal is a function of the environment and the individual's personality, cognitive style, etc. Appraisal, as the mediating cognitive activity, helps to make coping a process or transaction as opposed to a linear interaction. As stated earlier, no one personality type, stimulus or reaction is sufficient to understanding the coping process; many factors must be considered (Roskies and Lazarus, 1979).

Coping strategies

Coping strategies are considered to be those thoughts, behaviors and plans used by the individual to deal with stressful situations. The type of response chosen seems to be based on the individual determining the most desirable or least harmful outcome (Roskies and Lazarus, 1979). The purpose of this section is to discuss coping strategies. As well, broad categories of coping strategies and specific strategies have been identified and will be discussed. For ease and clarity of discussion, this section will be divided into four subsections.

What comprises a coping strategy? One proposal is that a coping strategy involves ego processes, such as maintaining a sense of self-worth, developing self esteem, and managing emotional distress which may arise when dealing with complex demands (Coelho, Hamburg and Murphy, 1963). The individual's personality, environmental demands and the appraisal process are important influences on coping strategies (Lazarus, 1975; Hamburg, Coelho and Adams, 1974).

Antonovsky (1979) identified three variables that comprise coping strategies. The first is rationality, i.e. an accurate, objective assessment of the stressor's threat potential, similar to Lazarus' idea of primary appraisal. A coping strategy may be irrational if there is an inaccurate assessment of the situation or of one's abilities. The second variable is flexibility - being able to and willing to change or update strategies (Antonovsky, 1979). This is similar to the concept of reappraisal. The third variable is farsightedness or the ability to anticipate the outcome of a certain coping strategy (Antonovsky, 1979). This relates to the whole appraisal process and the idea of receiving feedback from the coping strategy outcomes and making future decisions based on this.

Are defensive behaviors coping strategies? There is some disagreement in the literature as to whether or not defensive behaviors can be considered to be coping strategies. Alker (1968) distinguishes between coping behavior and defensive behavior: coping behavior is described as desirable, flexible, purposive and reality-oriented; defensive behavior is rigid, distorting, maladaptive and "permissive of impulse gratification through subterfuge" (p. 985). Weisman and Worden (1976-77) have a similar distinction between coping strategies and defensive reactions: coping is described as being aimed at resolution, mastery or control, while defensive behavior seeks disavowal or avoidance.

Other authors subsume defensive behaviors under the umbrella of coping strategies, describing it as above but also as beneficial and, at times, necessary (Lazarus, 1966; Monat and Lazarus, 1977; Folkman et al, 1979). For example, it has been found with individuals who have dealt with life threatening illnesses or injuries that denial is often used at first to minimize the impact of the illness or injury, to prevent the individual from being overwhelmed. This allows the individual "... to make a more gradual transition to the exceedingly difficult tasks that lie ahead" (Hamburg and Adams, 1967, p. 278). It seems reasonable to consider coping strategies to include defensive behaviors.

Types of coping strategies. Three major types of coping strategies were identified by Pearlin and Schooler (1978) in their research on coping and how people deal with stress in four different role areas. The first type of coping is responses that change the situation. This is a direct way to cope with life strains that is aimed at changing or eliminating the source of stress. It is not the most frequently used response as it is not always possible to identify the source of stress. Also, people may lack the knowledge or the ability needed to change or eliminate the source; the source may not be changeable; or the resolution of one source may activate another source of stress (Pearlin and Schooler, 1978).

The second category outlined is the attempt to control the meaning of the stressor after it occurs, but before the emergence of stress (Pearlin and Schooler, 1978). The individual may: cognitively make the stressor less threatening; overemphasize its positives while de-emphasizing its negative traits; or make other areas of his/her life more important than the area in which the source of stress originates.

The third type of response is one that deals with the management of the stress (Pearlin and Schooler, 1978). The individual tries to minimize his discomfort, while doing nothing about the source of stress.

Specific strategies. Specific strategies have been identified in the literature. Sidle et al (1969) derived ten coping strategies from the literature to develop a coping scale. The coping scale was developed to assess how individuals (specifically college students) cope with a given problem. The ten coping strategies are:

1. Try to find out more about the situation; seek additional information.
2. Talk with others about the problem (friend, relative, professional person).
3. Try to see the humorous aspects of the situation.
4. Don't worry about it. Everything will probably work out fine.
5. Become involved in other activities in order to keep your mind off the problem.
6. Take some positive concerted action on the basis of your present understanding of the situation.
7. Be prepared to expect the worst.
8. Make several alternate plans for handling the situation; after all, you never know which might work.
9. Draw upon your past experiences; perhaps you've been in a similar position before.
10. Try to reduce the tension (e.g. drink, eat, smoke more, exercise).

(Sidle et al, 1969, p. 227)

In intercorrelations of these strategies, Sidle et al (1969) found them to represent ten relatively independent ways of coping. These strategies can be used to illustrate the types of coping strategies described by Pearlin and Schooler (1978). For example, strategies 1, 2, 6, 8, and 9 could be considered to be responses in attempt to change the situation; strategies 3, 4, and 7 could be considered to control the meaning of the situation; and strategies 5 and 10 could relate to the individual trying to minimize his/her discomfort from the stress.

Jacobson (1976) expanded Sidle's list of coping strategies and modified the wording, as she felt that some strategies should be specific to the group that was being investigated (neonatal intensive care unit nurses). Jacobson (1976) felt that Sidle's strategy 9 (Draw upon your past experiences) was part of strategy 1 (Seek additional information about the situation); this investigator disagrees with this inclusion since strategy 1 is present or future oriented and perhaps less personal, while strategy 9 is past oriented and more personal.

Jacobson (1976) combined strategy 3 (Try to see the humorous aspects of the situation) with strategy 10 (Try to reduce the tension); this investigator agrees with this combination and Jacobson's reasoning that humor, particularly "gallow's humor", is a form of tension release. Strategy 7 (Be prepared to expect the worst) was eliminated from her study as Jacobson (1976) felt that it was implicit to the neonatal ICU environment. Three other strategies were added to Jacobson's (1976) list: fantasy; keeping one's perspective; and looking for philosophical and spiritual meaning to the experience. The following is Jacobson's (1976) list of coping strategies:

> 1. Seek more information about the situation.
> 2. Revise and rehearse your procedure for the next time it happens.
> 3. Try to reduce your tension.
> 4. Try to reduce your contact with the situation.
> 5. Use your interpersonal skills.
> 6. Try to "lighten or brighten" the unit environment.
> 7. Express yourself directly to the involved person(s).
> 8. Don't worry about it. These things happen. What's done is done.
> 9. Look for ways to keep your perspective on the situation.
> 10. Broaden the range of your influence and concern beyond you and your patients.
> 11. Search for philosophical and spiritual meaning in your experience.
> 12. Cultivate an objective, intellectual attitude.
> 13. Rework the situation in your imagination.
>
> (pp. 278-279)

Although the strategies listed here represent what are presently identified, this may not be comprehensive of the coping strategies available. This study will remain open to the possibility of discovering other strategies.

Classification of coping strategies

> A major goal of research on coping is to describe and classify the varieties of coping activities to provide

> a basis for their assessment and for the study of their antecedents and consequences. (Jacobson, 1976, p. 65)

Attempts have been made to classify coping strategies into comprehensive, coherent systems.

> Such a system should be exhaustive of main varieties [of coping] and yet, detailed enough to include individual forms within each category. (Jacobson, 1976, p. 65)

Different classification systems have been put forward in the literature. One such system is the use of defensive polarities, however, there are some difficulties with that model. Lazarus and his associates have put forward several classification schemes, from a fairly simple model (Lazarus, 1966) to a detailed, more comprehensive model (Lazarus and Launier, 1978). The more comprehensive model appears to have the potential for meeting the criteria outlined above by Jacobson (1976).

Some coping research has used the concept of defensive polarities to classify coping strategies (Lazarus, Averill and Opton, 1974). Three different approaches are found within this concept:

1. Repression-sensitization: This is a concept that is heavily researched in the personality literature. Repression is a hypothetical tendency to deal (cope) with threat "... by denying evidence of poor functioning, emotional disturbance and socially undesirable traits" (Lazarus, Averill and Opton, 1974, p. 252). Sensitization concedes that these traits are there and is oriented toward the "... discomforting aspects of living" (Jacobson, 1976, p. 67). The MMPI was used to determine these polarities, which were felt to represent classifications of coping strategies, i.e. people cope as repressors or sensitizers.

2. Repression-isolation: This approach is psychoanalytically oriented (Lazarus, Averill and Opton, 1974). Repressors show repressed

affect, a lack of reflection and intellectualization, and naivete when confronted with stress. Isolators have an opposite pattern and use reflection or intellectualization to deal with stress. The Rorschach test was used to identify these polarities.

3. Avoiders, copers and non-specific defenders: This approach was developed by Goldstein (1959) (Lazarus, Averill and Opton, 1974), using a sentence completion technique containing aggressive and sexual connotations. Avoiders avoid threatening contact; copers are oriented toward intellectually dealing with threat; and non-specific defenders fall between avoiders and copers, using neither type of defense to the exclusion of the other, but using that response which is appropriate for the moment.

There are three major issues regarding the use of defensive polarities to classify coping strategies. The first involves the tests that were used to determine these polarities. The construct validity is in question as the tests used may not have measured the same things nor have had the same meaning: "There is considerable reason to doubt that such terms as repression, denial and avoidance have comparable meanings from one investigator to another or that the personality assessment tests used ... [to measure coping] are indeed measuring the same disposition" (Jacobson, 1976, p. 68). The unconscious handling of psychological threat may not have been what was measured.

The second issue is the limited nature of this model as a classification scheme. The polarities consider only intrapsychic coping strategies and not those that may involve direct action. The possible impact of situational constraints was not considered and only a limited number of intrapsychic strategies were identified (Jacobson, 1976).

The third issue is whether or not important types of responses were identified, as "[even] limited schemes may still deal with significant forms of coping" (Jacobson, 1976, p. 69). Although, as a classification system, defensive polarities are limited, the research has been important and may contribute to the development of a more comprehensive system (Jacobson, 1976).

Lazarus (1966) proposed a classification system with two categories: direct action and defense mechanisms. Direct actions are aimed at getting rid of or changing "... the anticipated harmful confrontation that defines threat" (p. 258). Defense mechanisms are cognitive strategies which modify an appraisal without directing action at changing the objective situation (defensive reappraisal).

Lazarus, Averill and Opton (1974) also discuss two categories or modes of coping strategies: direct action on self or environment and a mode that functions primarily through intrapsychic processes. These are similar to Lazarus' (1966) concepts, but three main subtypes were added to the intrapsychic mode:

1. Attention deployment: An attempt to tune out that which is threatening by focusing attention elsewhere or thinking only about the positive things.

2. Defensive reappraisal: Cope with threat by misinterpreting the situation, leading to a benign appraisal.

3. Wish fulfilling fantasies.

Lazarus, Averill and Opton (1974) point out that direct action and intrapsychic processes are not considered to be mutually exclusive. It is believed that cognitive processes go along with particular direct actions and vice versa (Lazarus, Averill and Opton, 1974). However, it is important to distinguish between the two modes because:

> ... conditions determining the choice of coping should vary not only among individual forms of coping, but also between the modes themselves. (Lazarus, Averill and Opton, 1974, p. 262)

The use of direct action to cope depends upon the individual and the circumstances; if direct action is not possible, then an intrapsychic process is the alternative.

Intrapsychic processes have also been referred to as palliation and further described as ways of reducing effective, visceral or motor disturbances when direct action is too costly to the individual or too difficult to manage (Lazarus, 1974; 1975).

Lazarus and Launier (1978) further expanded this classification system, as they felt that previous proposals were inadequate and limited. The categories of direct action and intrapsychic processes have been placed with other coping modes within this new scheme, under two main headings within "Functions": 1.) Altering the troubled transaction (instrumental) and 2.) Regulating the emotion (palliation). Table 1 illustrates this classification system. This system includes: temporal orientation of coping (past-present or future); instrumental focus (focus on self, environment or both); relevant appraisals (whether it is a harm-loss, threat or challenge situation); the thematic character; and the coping modes (information seeking, direct action, inhibition of action and intrapsychic modes).

The temporal distinction is needed as it is believed that coping with past-present harm-loss requires different cognitions and actions, hence strategies, than coping with future harm (threat or challenge). This difference is reflected in the thematic character:

TABLE 1
Coping Classification Scheme

	Temporal orientation			
	Past-present		Future	
	Functions			
Self	1. Altering the troubled transaction (instrumental)	2. Regulating the emotion (palliation)	1. Altering the troubled transaction (instrumental)	2. Regulating the emotion (palliation)
	Coping modes			
	a. information seeking		a. information seeking	
	b. direct action		b. direct action	
	c. inhibition of action		c. inhibition of action	
	d. intrapsychic		d. intrapsychic	
	Functions			
Environment	1. Altering the troubled transaction (instrumental)	2. Regulating the emotion (palliation)	1. Altering the troubled transaction (instrumental)	2. Regulating the emotion (palliation)
	Coping modes			
	a. information seeking		a. information seeking	
	b. direct action		b. direct action	
	c. inhibition of action		c. inhibition of action	
	d. intrapsychic		d. intrapsychic	
	Appraisals			
	Harm		Threat or challenge; maintenance	
	Thematic character			
	Overcoming, tolerating, making restitution, reinterpreting past in present		Preventive or growth-oriented processes	

Derived from Lazarus and Launier, 1978, p. 312.

> ... past harm-loss must be overcome, tolerated, made restitution for or reinterpreted in the context of the present ...
>
> [threat] needs attempts at maintaining the status quo or preventing that harm by taking action to head it off or neutralize it. (Lazarus and Launier, 1978, p. 313)

Challenge is dealing with stress in the future perspective, but is appraised in a "... positive, potential gain sense" (Lazarus and Launier, 1978, p. 313). Although both are future oriented, threat appraisal focuses on prevention of harm, while challenge is directed at growth.

Within this system, coping may be directed at self, environment or both:

> ... since either or both can be appraised by the individual as responsible for the troubled person-environment relationship (stress) ... conditions determining the choice of coping should vary not only among individual forms of coping, but also between the modes themselves. (Lazarus and Launier, 1978, p. 314)

Also, these coping foci are applicable with either of the temporal orientations.

Lazarus and Launier (1978) identified two main functions of coping within each coping focus. The first is an instrumental or problem-solving function, which is intended to affect the stressed person-environment transaction. The second is palliation, which controls the emotional reaction arising from the stress transaction; note that palliation is a major function in this model with intrapsychic processes as one of the modes. A great deal of coping is directed at the problem-solving aspects of a stress situation; the following examples illustrate the importance of instrumental coping:

> A danger must be avoided or protected against; a strong commitment can only be realized by taking steps to do what is necessary to attain it; if one is seriously injured, medical help may have to be sought; ... if one

> does not know what is wrong or what to do, information about the situation must be sought. (Lazarus, 1978, p. 315)

The palliative function is believed to be important for three reasons (Lazarus and Launier, 1978):

1. Because of the painful and distressing nature of stress emotions, an individual must acquire both "healthy" and "pathological" modes of coping (e.g. defense mechanisms).

2. Since strong emotions can interfere with coping through distraction or selective attention, it is important to be able to temper the emotion, "... not merely by mastering the impaired transaction (which may be impossible), but by directly regulating the emotional state itself" (p. 315).

3. Arousal due to stress can upset the "internal milieu" of an individual. By being able to regulate emotional reactions, arousal that may lead to ill health can be lessened. "It would make little sense for the person to act in the interests of psychological survival only to succumb physiologically in the process" (p. 316).

Within each coping function, there are four coping modes. These modes can fit into either temporal orientation and can be directed at the self or the environment. These modes are:

1. Information seeking: This can serve either function, e.g. by actively seeking information (instrumental) or by seeking only positive information (palliative). It can be used to reinterpret a past harm or reduce a threat.

2. Direct action: This may be instrumental (requesting that someone stop a behavior that disturbs you) or may be palliative (drink-

ing, smoking more, taking drugs, meditating). Direct action can be used to overcome a past harm (a grieving individual throwing himself/herself into his/her work) or a future threat (building a bomb shelter) and to change an individual (go on a diet, stop smoking) or an environment (seeking revenge, picketing for social change).

3. Inhibition of action: This responds to the constraints placed upon us due to our beliefs, societal standards, etc. Yelling at the boss may be a direct way to cope, but inhibiting that action may be more prudent.

4. Intrapsychic modes: These are cognitive processes that help to regulate emotion so that the individual can feel better. These may be things one says to himself/herself or ways of re-focusing one's attention. Intrapsychic modes can be instrumental (reassuring oneself prior to an important interview to lower one's anxiety level) or palliative (regulating emotion to reduce anxiety or distress) and can have a self or environmental focus.

Lazarus and Launier's (1978) classification system seems to meet Jacobson's (1976) recommendations better than the other models described. This model takes into account two major functions of coping, two temporal factors, two foci of coping, the two types of appraisal of the situation and the thematic character of those appraisals, and four coping modes. The model is not totally comprehensive as Lazarus and Launier (1978) mention other coping functions that may be possible, but are not included in their model, such as maintaining one's options, tolerating or relieving affective distress or maintaining positive morale. These functions may be possibly included in this model by considering them to be strategies: for example, maintaining one's options or positive morale may fall under direct actions; relieving affective distress may fall into the intrapsychic mode. However, as this shows, this model is not all inclusive and has weaknesses. But it is a model with potential for understanding the coping process and the many factors that can be involved. It will likely be built upon and modified as the volume of research on the psychology of coping increases.

Coping resources

Coping resources are those resources available to an individual in the development of coping responses (Pearlin and Schooler, 1978). Resources are not considered to be constant over time, but may change depending upon an individual's experiences, amount of stress, time of life and amount of coping needed (Folkman et al, 1979). As with the other areas of coping research, there is not a great deal of information about what resources people draw upon when they cope, however, coping resources are known to be important (Folkman et al, 1979). There have been coping resources identified in the literature which will be discussed. It is not known if the resources identified exhaust all the available resources; further research is needed in this area.

There are two reasons why coping resources are important (Folkman et al, 1979). Coping resources provide an individual with information to evaluate when appraising the impact of a stimulus on his/her well-being; they also "... provide the basis of coping action, depending on the knowledge about them and how they can be used" (p. 284).

Pearlin and Schooler (1978) in their research on the structure of coping distinguished between two types of resources used in coping.

Social resources or those supports one has in one's life (such as family, friends, co-workers) were felt to be important. This is supported by other authors (Hamburg, Coelho and Adams, 1974; Antonovsky, 1979; Patrick, 1981; Vachon, 1978; Folkman et al, 1979). When an individual has a sense of belonging to a valued group, they are better able to cope; it was found that survivors of Nazi prison camps were likely to be those who kept their personal systems intact and had group support (Hamburg et al, 1974).

The second resource identified by Pearlin and Schooler (1978) is psychological resources. These are personality traits that individuals use when dealing with threats from the environment; these resources are within the individual and represent what people are, independent of their roles.

Folkman et al (1979), who alsoinvestigated coping resources, appear to have a more comprehensive model and have identified five resources:

1. health/energy/morale: This is described as the most obvious resource. If someone is ill, tired or depressed, he/she is less likely to cope as well as someone who is healthy, rested and in good spirits. Andreasen et al (1972) found with burn patients that "... premorbid psychopathology and physical disabilities significantly predict poor adjustment to the immediate trauma of burns" (Folkman et al, 1979, p. 284).

2. problem solving skills: Included here are abilities to seek new information, analyze a situation, come up with alternatives, anticipate outcomes of specific actions and follow through with appropriate plans of action.

3. social networks: The ideas here support the previous authors cited. Strong, supportive relationships can help individuals deal with stress. Social supports can also affect other resources such as health/energy/morale. People with strong social networks have been found to live longer than people who are isolates (Berkman, 1977).

4. utilitarian resources: These are resources available within the environment, such as money, tools, special programs, etc. These resources may help to open up more options for coping; e.g. more money may help someone to get away from stress by taking a vacation, seeking professional or medical help, etc. Important here is that people need to be aware of the utilitarian resources available and how to use them.

5. specific and general beliefs: Bandura's (1977) emphasis on the belief of self-efficacy fits into this category. Those who believe in their ability to cope are better able to deal with stressors. People who lack faith in their ability to cope or master a situation may be threatened in situations that do not threaten the ordinary individual, therefore they may have to deal with more stress. Belief systems can be very broad or very narrow and can influence whether or not an individual feels in control of what is happening or feels the focus is outside of himself/herself. Religious beliefs can affect how an individual appraises a situation. Also, beliefs can affect other resources an individual has, like morale: "Morale can be bolstered and hope generated, for example, by the belief that suffering is good for the character" (Folkman et al, 1979, p. 288).

These resources that have been identified will be considered when analyzing the information from the subjects in this study. This study will remain open to the possibility of finding other resources.

Coping effectiveness

Coping efficacy is a measure of how well coping prevents the threats or stressors from leading to emotional/psychological stress or how it mediates the stress once it occurs. Weisman and Worden (1976-77) consider that:

> Successful coping requires a balance of what one can accept or confront and what can be harmlessly ignored or postponed. (p. 13)

Coping effectiveness has been found to depend on the number of strategies and resources available, how the strategies are used, the situation, the individual and the amount of stress involved. More information is required on the variables which influence effective coping.

Sidle et al (1969) noted in their study of college students dealing with stressful situations that: "A successful outcome may be arrived at through the use of a number of different strategies" (p. 231). Jacobson (1976) also acknowledged the importance of accepting a wider range of coping behaviors for neonatal intensive care nurses in coping with stress. The more strategies and resources an individual had at his/her disposal, the more effective their coping was likely to be.

Monat and Lazarus (1977) found that the optimal coping response depended upon the situation, the individual's perspective and judgement and how the strategy was used. A defense reaction such as denial can be an effective way to deal with an issue by preventing an individual from being overwhelmed by a situation (e.g. discovering you have a terminal disease and denying it initially until you recover from the shock). It can also be an ineffective way to cope (e.g. the woman who discovers a lump on her breast and then denies its existence and does not have it checked).

In a study of coping in four major role areas (marriage, parenting, household economics and occupation) a variation in coping effectiveness was found (Pearlin and Schooler, 1978). Coping was found to have more impact on areas such as marriage, parenting and household economics than in areas that were impersonally organized such as occupation. Coping with occupational stress may require more of a collective intervention than individual intervention. In the occupational and economic roles, manipulation of goals and values seemed to be the coping strategies with the most impact. Also, effective coping seemed affected by not only what the individuals did, but also by how much they did.

Coping effectiveness is believed to be less under conditions of severe stress (Hamburg, Coelho and Adams, 1974; Lazarus, 1966; Lazarus, Averill and Opton, 1974). Under conditions of severe stress, there appears to be regression to simpler forms of coping:

> ... under severe stress, with relatively intense emotional responses, developmentally earlier and simpler forms of coping are more likely to appear than are novel or complex ones. Elsewhere, the literature indicates that it is very difficult for individuals to improvise under high stress conditions and it is much more likely that long established overlearned patterns of response will be applied rather than new ones specifically tailored to the situation. (Hamburg et al, 1974, p. 434)

The most effective forms of coping seem to occur under moderate stress (Lazarus, 1966).

There are two possible reasons for the relationship between simpler forms of coping and the degree of threat (Lazarus, 1966).

Cognitive functioning may be disrupted due to the threat limiting the individual's perceptual field. Also, a strong threat indicates a goal of great importance is threatened; the more important the goal, the more extreme the coping strategies.

> When the stakes are judged to be high and the outcome difficult to manage effectively, strong emotions typically follow and there is a greater likelihood of ineffective, rigid and primitive forms of coping, such as reality distorting defenses. (Lazarus, Averill and Opton, 1974, pp. 260-261)

More information is needed on the variables which influence effective and ineffective coping. It is likely true that all people cope adequately with some stressors and that all people are likely to fail to cope with the stress in some situations, but little is known about the range of coping effectiveness (Roskies and Lazarus, 1979). There is no "rule" about what strategies are effective, when or why. It seems that whether an instrumental or palliative form of coping is more effective depends upon the situation and the individual, his/her beliefs, values, etc. Eastern cultures seem to place more value on "bending with the wind" (Roskies and Lazarus, 1979, p. 55), rather than taking direct action, indicating cultural expectations of effective coping. In the end then, it seems that truly functional coping is defined:

> ... as that which not only lessens the immediate impact of stress, but also allows the person to maintain some sense of self-worth and unity with the past and future... (Roskies and Lazarus, 1979, p. 55)

CHAPTER III

METHODOLOGY

General purpose of research

The purpose of this study is to investigate how nurses cope with stress encountered working in an oncology setting. More specifically:

1. What coping strategies are used?
2. What coping resources are used?
3. How effective do the nurses consider their strategies to be?
4. What blocks the nurses from coping better with job related stress? What do they feel would help them to cope better?
5. Does there seem to be any difference due to the demographic variables of: working full time or part time; length of time as a nurse; and length of time as a ward nurse in an oncology setting?

The Setting

The setting from which the subjects were drawn was the W.W. Cross Cancer Institute, Edmonton. The Institute is a provincially run hospital, serving patients from central and northern Alberta as well as the Northwest Territories. It is a comprehensive cancer treatment center which treats patients at all stages of disease, from the diagnostic phase to palliation, providing day care, outpatient and inpatient treatment services.

The Institute has an active treatment focus on cure or control of the disease; to this end, the Institute offers specialized treatment (radiotherapy, chemotherapy, immunotherapy) as well as experimental treatment modalities. The Institute is also an active research facility and is used as a teaching hospital by the University of Alberta in the area of oncology.

Sample

A sample of nurses with consistent exposure to the stresses encountered in an oncology setting was necessary. Such a sample would theoretically experience the numerous stresses associated with cancer nursing arising from ongoing involvement with death, distressed families, dying patients and interactions with physicians and colleagues. The ward nurses at the Cross Cancer Institute, Edmonton met the criteria for the study. Nurses functioning in other parts of the hospital (nurses in the outpatient department, surgery, etc.) were not investigated to control for secondary variation that may have arisen due to different working conditions, working hours and duties.

Subjects were selected from the ward nurses according to the following criteria:

1. A willingness to participate.

2. Nurses selected must have worked on the wards at the Cross Cancer Institute for three months or more. Those who worked at the hospital for less than three months were not selected due to the additional stress they must cope with when beginning a new job and dealing with its expectations; this type of stress and how it is dealt with was not under investigation.

Procedure

The investigator met with the ward nurses during the report periods at the beginning of their shifts to explain the study and request their involvement. The nurses filled out a data sheet to indicate demographic variables as well as their willingness to participate. Those nurses who submitted data sheets were screened according to the above criteria and then sorted into categories according to: whether or not they worked full time or part time; the number of months as a ward nurse at the hospital (3 to 12 months, 13 to 24 months, 25+ months); and the number of years of nursing experience (0 to 1 year, 1 to 5 years, 5+ years). Once sorted into these categories, five nurses were selected randomly from the categories where there was more than one respondent for the pilot study. Fourteen other subjects were then selected, one from each category, for the actual study. For those category combinations with only one subject, that subject was selected arbitrarily for the actual study. The reason for using the categories was to determine if there were any differences in coping strategies, resources and effectiveness that could be determined demographically. Table 2 illustrates the categories that were used.

During the meetings with the ward nurses, they were advised that the interviews would take approximately one to one and one half hours and that anything they shared with the interviewer would be kept confidential. Consent was obtained from the Cross Cancer Institute to carry out this study, prior to the meetings with the nurses.

Pilot study

A pilot study is recommended when using an interview format to

TABLE 2

Demographic variables

			Experience in current position(months)		
			3 - 12	13 - 24	25+
Employed full time	Nursing experience (years)	0 - 1		xxx	xxx
		1 - 5			
		5+			

			Experience in current position(months)		
			3 - 12	13 - 24	25+
Employed part time	Nursing experience (years)	0 - 1		xxx	xxx
		1 - 5			
		5+			

xxx - indicates combinations that are not possible.

help evaluate, clarify and focus the questions, as well as give the interviewer experience with the process (Borg and Gall, 1971; Richardson et al, 1965; Kerlinger, 1965). This also helps to establish the reliability of the questions (Kerlinger, 1965; Borg and Gall, 1971). The subjects for a pilot study should be taken from the same population as the sample under investigation (Borg and Gall, 1971). Five nurses were selected for the pilot study.

After the five subjects were contacted and an interview time scheduled, the following procedures were followed:

1. Permission from each subject was requested to tape the interview and again their anonymity was assured.

2. A standardized, brief overview of the research area was given so the subjects would have a common understanding of what was being sought. Such an understanding is known to be important to the interview process (Richardson et al, 1965).

3. The format of the interview was explained and the subjects were encouraged to ask questions or for clarification at any time.

4. The demographic information was confirmed and questions regarding how they came to be nurses and their educational background were asked to develop rapport and comfort using low threat questions.

5. The interview format was then followed, with clarification sought where it was felt to be necessary by the interviewer, so that the respondent's perceptions and ideas were better understood.

6. At the end of the interview, feedback was sought from the subjects regarding the interview process and to see if they had any information they wished to add.

During the interviews and after their completion, revisions were made to the interview format to clarify and focus some of the questions, as well as remove some and add others. Portions of the tapes were played back to a thesis committee member for feedback and suggestions.

Once the interview format was finalized, the fourteen subjects for the actual study were contacted and interviewed, using the same procedural guidelines outlined above. The interview format used can be found in Appendix E.

Instrumentation

In this type of exploratory research, there are instrumentation alternatives, each with its strengths and deficits.

The questionnaire format was given considerable thought by this researcher. However, its use is recommended when factual, unambiguous information is sought; it can be too 'shallow' and unable to depict true feelings and opinions (Borg and Gall, 1971). Since the area of coping research tends to rely upon the perceptions and feelings of the individual, which are not always clear and factual, the questionnaire did not seem appropriate. There are additional difficulties with the questionnaire: a low percentage of return; the questions may take on different meanings to different people, which cannot be clarified nor explored; people may object to writing a sufficient answer to an open ended question if a long response is elicited; and many people cannot adequately express themselves in writing (Kerlinger, 1965).

The alternative methodology commonly used is the interview format. The principal appeal of the interview is its flexibility and adaptability; the interviewer is able to follow up on specific points and seek greater clarification (Borg and Gall, 1971; Guba, 1979;

Kerlinger, 1965; Richardson et al, 1965). Also, by developing rapport with the respondent, the interviewer may be able to elicit information the subject might not otherwise discuss (Borg and Gall, 1971). The interview"... provides information about an individual's perceptions, beliefs, past behaviors and future plans" (Kleinmutz, 1967, p. 143).

There are two main types of interview: standardized or structured and non-standardized or unstructured (Kerlinger, 1965; Borg and Gall, 1971; Kleinmutz, 1967; Guba, 1979; Richardson et al, 1965). There is also a semi-structured form of interview (Borg and Gall, 1971).

With the structured interview, the questions, their sequence and their wording are fixed (Kerlinger, 1965; Kleinmutz, 1967; Guba, 1979; Richardson et al, 1965). Richardson et al (1965) discuss two types of standardized interview: schedule and non-schedule. The schedule standardized interview asks questions in a prescribed sequence, with an option for deeper exploration into different responses by the interviewer. The purpose for using the same questions in the same order is to encourage validity. Also, questions that are asked initially are usually less threatening and are used to involve the subject. Questions that need more thought and effort or that are threatening are asked toward the end of the interview, after comfort and rapport have developed. The schedule standardized interview is similar to the semi-structured interview proposed by Borg and Gall (1971). The semi-structured interview is described as having highly structured questions, but with open ended questions and the permission to probe more deeply for clarification of ideas (Borg and Gall, 1971). The questions may vary from being closed to being open ended within the interview process; this allows for reasonable objectivity with more thorough understanding of the subject's answers (Borg and Gall, 1971). This approach is supported by Kerlinger (1965):

> The best instrument for sounding people's behavior, future intentions, feelings, attitudes and reasons for behavior seems to be the structured interview that uses open ended, closed and scale items. (p. 476)

The non-schedule interview differs by formulating the wording in each question so that it is appropriate for each subject:

> ... the non-schedule interviewer formulates the class of information he is seeking and hopes he can formulate the questions in such a way that they will have the same meaning for each respondent. (Richardson et al, 1965, p. 45)

Non-schedule standardized interviews seem more appropriate when interviewing individuals from a heterogenous group and when exploring very sensitive material (Richardson et al, 1965).

The non-standardized interview is less directive and unstructured, allowing the conversation to take its own direction (Kleinmutz, 1967). The questions are not predetermined; this is akin to a Rogerian approach.

The type of interview process most appropriate for this study is the schedule standardized interview or the semi-structured interview, which will henceforth be referred to as semi-structured.

When constructing the items for the interview format, the following criteria were taken into account: the questions should relate to the problems and objectives under consideration; the appropriate type of question should be used for the information sought (closed, open ended or scale items); the items should be clear and unambiguous, focusing on one idea at a time; the questions should not be leading nor demand knowledge the subject does not have; rapport must be developed before any personal or delicate issues are explored; the items should not be structured so as to cause the subject to disapprove of herself; and the questions should not be loaded with social desirability (Kerlinger, 1965).

Validity is difficult to achieve due to the potential influence of interviewer bias. An attempt to control for this was made by using the semi-structured interview format.

The interview schedule

The interview schedule was in basically three parts and had been designed according to the recommended guidelines in the literature. The first stage included the confirmation of the demographic information and the respondent's perception of stress, coping and their coping effectiveness.

In the second part of the interview, five stressful incidents that the nurses might encounter on their jobs were presented to the subjects to read. Three senior nursing staff at the hospital were asked to generate three to four incidents for each stressor identified by Arcand (1980) (see Appendix C). Short stories/incidents have been used before to measure coping (Sidle et al, 1969; Jacobson, 1976). A unique aspect of this study is the use of this type of incident in the interview format. Once the incidents were generated, two other senior nursing staff were asked to pick two incidents from each set of incidents that best illustrated that stressor, with minimum contamination from the other stressors. The purpose of this was to give the incidents some degree of validity. Consensus was achieved only on one incident in each set. It was decided that the five incidents that were agreed upon as the most stressful would be used in the interview process (see Appendix C).

Part three of the interview included a list of coping strategies. Sidle et al (1969) derived a list of coping strategies from the literature that represented ten fairly independent measures of coping.

Jacobson (1976) modified the ten strategies when she studied the coping strategies of nurses working in a neonatal intensive care unit. Jacobson (1976) felt that coping strategies should have the following characteristics:

1. They should exhaust the range of coping strategies known to be available.

2. The strategies should be phrased concretely to avoid terms that are too abstract or too psychological.

3. They should be phrased generally to represent classes of specific actions.

4. They should be phrased neutrally to avoid a positive response set.

Jacobson (1976) agreed with Sidle's recommendation to keep the wording of strategies uniform rather than to change the wording to reflect the incident being coped with.

Jacobson (1976) expanded the list of coping strategies identified by Sidle et al (1969) to thirteen and gave examples of each strategy, so that the subjects would have a common understanding of what was meant by each strategy. The expanded list included strategies dealing with fantasy, keeping perspective on a situation and looking for philosophical and spiritual meaning from an experience. The lists of Sidle et al's (1969) and Jacobson's (1976) strategies can be found in Chapter II. The strategies used in the interview are in Appendix D. Part three of the interview also included an opportunity for the respondents to give feedback on the interview process and to add any other comments they wished to make.

Analysis of Data

Given that this was an exploratory study and consequently, a descriptive study, no statistical procedures were applied to the data. Each interview was listened to twice in an attempt to identify themes and trends in the individuals' coping strategies, resources and effectiveness. A synopsis of each interview was written using the following outline:

1. Demographic variables: These were kept general to protect the anonymity of the respondents.
2. Coping strategies identified when dealing with stress generally.
3. Situational examples (stress encountered, strategies used and "felt" effectiveness).
4. What may be blocking the individual from coping better with job related stress.
5. What may help the individual to cope better with job related stress.
6. Coping resources: Those identified specifically or referred to when discussing the coping strategies.
7. "Felt" effectiveness of coping strategies overall.
8. Enough strategies for coping with stress?
9. Comments (by the respondents).
10. Summary.

A table, illustrating the use of the coping strategies from the list presented to the respondents, was made to give an overview of how frequently these strategies were used.

Limitations

Due to the nature of the interview process, the number of subjects and the exploratory nature of this study, the generalizability of the results may be limited to the nurses in the setting from which the sample was drawn. However, this is not necessarily a detriment. This study may help to provide a basis for more rigorous, empirical research using a larger, more diverse sample. Also, the information obtained may prove helpful within the setting these nurses work in. These limitations need to be considered when reviewing the results.

CHAPTER IV

RESULTS

The purpose of this chapter is to present the results from the fourteen interviews that were conducted. The request for participation in this study was presented to 51 nurses at the Cross Cancer Institute, Edmonton. From these 51 respondents, 39 were willing to participate and twelve were not. The twelve who were not willing to participate cited reasons such as: not having enough time; a dislike of being taped; and not having worked long enough at the hospital to be able to give enough information.

From the 39 ward nurses who were willing to participate, five were selected at random to participate in the pilot study. The pilot study did help to refine and clarify the interview process.

Fourteen nurses were then selected for the actual study, randomly from the categories where there was more than one respondent and arbitrarily from categories with only one respondent. Each category had at least one respondent.

A synopsis of each interview was written from rough notes that were taken while each tape was listened to twice. The information presented is a report of what the subjects said with an attempt to control interpretation or judgement of their statements by this writer, except in the section designated "Summary".

Each interview is divided into the following categories: demographic variables; coping strategies identified when dealing with stress generally; situational examples (see Appendix C); what may be blocking the individual from coping better with job related stress; what may help the individual to cope better with job related stress; coping resources; "felt" effectiveness of coping strategies overall; enough strategies for coping with stress?; comments; and summary. The subsections within the section on coping resources are from Folkman et al's (1979) model. At the end of the chapter is a table illustrating the use of the list of coping strategies presented to the respondents during the interview (see Appendix D).

Each synopsis is meant to be brief and to summarize those points which seem to best reflect the nature of the individual's coping and that which influences it.

Case Descriptions

Subject A

Works full time, has 0 - 1 years nursing experience and has been a ward nurse for 3 - 12 months.

Coping strategies identified when dealing with stress generally. When A is feeling stressed, she has physiological indicators such as: sweaty palms, and rapid heart rate and respiration. She finds that she gets upset more easily, may cry more readily and is not as patient. These indicators are more noticeable for A when she is under severe stress.

A described coping with stress as being able to recognize having stress, so that she can find outlets for it, channel it and use it appropriately and positively. A uses the following coping strategies: recognizing that she is under stress; taking deep breaths and talking to herself to calm herself down; setting her priorities and doing one thing at a time; taking a bath; doing something physical; and talking to her roommate. A channels her stress into doing her work with more energy and motivation, so that she does things more quickly and efficiently: "If you let it [stress] take over your body, then you are fumbling and drop things, but if you can take control sort of, you can channel it and use it ..."

Situational examples (stress encountered, strategies used and "felt" effectiveness).

Situation 1. A would find this situation stressful and would feel sadness (for the patient) and anxiety (due to the treatment required, the suddeness of his death and his youth).

A would cope with her feelings by talking to other staff and with the patient's family. She finds the support from the staff to be excellent. A would also consider her philosophy about death to help herself deal with the stress:

> I think that you don't have to cure someone in order to be successful and that if you help someone to a peaceful death that you are just as successful as you are if you help them to live. And dying is a really important part of life and it's a very important step and it should be fully appreciated and fully shared with the family and that it should be a very honest time and a very open time. I think we should try to help the family in order to fully experience it. It's not something that should be gotten over quickly or hidden or anything like that ...

A feels her philosophy keeps her from being devastated by the deaths she encounters and from feeling like she has failed.

A feels she copes effectively with this type of situational stress. She finds it also helps her to cope if she keeps work and her home life separate. As well, she finds that the twelve hour shifts and the subsequent time off also help her to cope with her stress.

Situation 2. A would find this situation really stressful. She would feel helpless, sad and angry or bitter (toward cancer and the suffering it can cause).

Coping strategies for A with this stress would be: talking with other nurses ("It helps to find out others feel the same way"); and help the patient to feel more comfortable (helping the patient really helps A reduce her stress).

These coping strategies are effective ways for A to cope with her stress in this situation.

Situation 3. A found this to be an accurate and stressful situation. She would feel mainly frustration.

To cope with her stress, A would: explain to all of her patients her time pressures and she would use other resources to help her with the distraught patient (pastoral care, psychologists). A would also use her stress in this situation to move more quickly.

A finds these are good ways for her to cope with her stress. When she first graduated from nursing school, she wouldn't use other supports as she felt she had to do everything herself. It was a good realization for A when she started to get help from others.

Situation 4. This would be a stressful situation for A. She would feel anger (at the family's attitude as she knows she would be trying her best with the patient) and frustration. She might "come down" on herself for not being able to connect with the family.

To cope with her stressful feelings, A might: leave the room (to gather her thoughts and check out what she had done with another nurse); talk with the family; and get involved in a physical activity outside the hospital.

A has not had this situation happen, but feels her strategies would help her to cope effectively with the stress she would feel.

Situation 5. A felt that this situation would be stressful for her. She feels somewhat "overawed" by doctors and would feel angry as well.

She hoped she would use the coping strategy of talking to the doctor to relieve her stress, but doubted that she would. She might talk to her roommate or to the other nurses or cry.

A felt she would likely deal effectively with the stress if she spoke with the doctor. If she didn't speak with him, the stress wouldn't be quite resolved for her, but she didn't feel it would bother her for too long.

What may be blocking the individual from coping better with job related stress? a.) at work: A has not found anything at work that blocks her from coping with stress. She has found the hospital helpful and flexible when helping staff to deal with work related and personal stress.

b.) in herself: A finds she does not always do what she needs to do to relieve stress (e.g. avoiding talking with someone).

c.) in others: nothing.

What may help the individual to deal better with job related stress?

a.) at work: nothing.

b.) in herself: A feels she needs to confront more that which stresses her.

c.) in others: She finds she has many good supports and could think of nothing to add.

Coping resources. a.) social supports: her roommate, other nurses (staff is extremely supportive).

b.) health/energy/morale: A gets involved in physical activities and also tries to maintain a very positive attitude when dealing with stress.

c.) utilitarian resources: support services (pastoral care, the psychologists), time off between shifts.

d.) general and specific beliefs: A's philosophy regarding death and dying is very helpful to her. She also tries to keep a positive attitude in dealing with that which stresses her.

e.) problem-solving skills: A can usually identify stressors and think of something to do to cope with her stress.

"Felt" effectiveness of coping strategies overall. A feels she copes quite well overall with her stress. She knows she has coped effectively with stress when she is left with a good feeling, all her work has been accomplished and everything is settled; she feels calm and successful.

Enough strategies for coping with stress? A is planning on attending a stress management workshop as she feels she can learn more about dealing with stress.

Comments. A found the situations to be realistic and stressful.

Summary. A does not feel much stress and does not think she has experienced really severe stress. She feels this is due to her attitude and to her ability to identify and cope with stress. Her philosophy regarding death and dying and her positive outlook and approach to life seem to be very important in helping A to cope. She finds she copes effectively overall with her stress.

Subject B

Works full time, has 1 - 5 years experience and has been a ward nurse for 3 - 12 months.

Coping strategies identified when dealing with stress generally. B's stress indicators are: irritability (mainly with her family); being easily moved to tears; the urge to eat; fatigue; leg aches; and dreams about patients. Recently, B has had a foreboding feeling about having an accident and dying; she wondered if this might be feelings of stress coming out.

B described coping with stress as finding ways to alleviate mental, emotional and physical pressure. Coping strategies B uses to deal with stress are: eating, taking pain killers for leg aches, being by herself (spending her time quiety or actively) and doing work at home.

Situational examples.

Situation 1. B did not think that she would find this situation stressful, due to the short length of time she would have been involved with the patient. Her stress would have depended upon how the patient and his family reacted to his illness as well. B would have found it stressful if the patient was calling for help and apprehensive until he died as she would feel frustrated and helpless.

B was uncertain whether or not she deals with her stress in this type of situation and, if she deals with it, how she would do that.

Situation 2. This situation would be stressful for B. She would feel anger (at not being able to get the patient settled), sadness and helplessness (due to the lack of pain control).

One strategy B might use in this situation was to do something for the patient, such as sit with them, talk, rub their back, hold their hand, try to get more analgesic from the doctor and give the analgesic as often as allowed. She felt that doing something for the patient would help to relieve her own stress. Other strategies that she might use to cope with her stress were: eating; exercising at home; and telling her husband and children how she feels.

As for effectiveness, B felt her effectiveness was okay and the strategies were the only ways for her to cope with the situation: "I can't take anyone's disease on myself ... It's just unreasonable to think that and so there's only so much you can do." B has found that if feels good to talk about her feelings in this situation; it doesn't let her get over her feelings right away, but it helps her to get on with her life.

Situation 3. B described this situation as extremely stressful. She would have felt frustrated and pressured with so many things to do.

Strategies that B might have used were: getting some help from other staff; reorganizing herself to "do first things first", i.e. the physical care; and asking someone else to sit with the patient (another nurse, a psychologist).

B felt these would be effective ways for her to deal with her stress, but wondered whether she was laying the problem (of the distraught patient) onto someone else: "... You know when you're with someone who is depressed and lonely and that kind of thing, you know, it can get you too and maybe I'd only be too happy to let someone else take it, because I wouldn't want to face those feelings at that particular time."

Situation 4. B felt this situation would be stressful for her. She would have felt annoyed (at "being hassled by the family") and hot and flushed.

She would have coped with her stress by: talking it over with the head nurse or supervisor or with other nurses at her break; trying to consider the family's perspective; and thinking over the situation.

The effectiveness of these strategies for B would have depended on how angry she was. Somtimes it takes her a couple of hours before her stress goes; she felt the stress from this situation would not linger. B would have rather talked about the situation with others than reworked it in her mind as she has found that situations sometimes get out of proportion when she thinks a lot about them.

Situation 5. B described this situation as somewhat stressful; she would have felt anger initially.

To cope with her anger, she might talk with others, just forget about it or do some physical work.

These methods seem to be effective for B.

What may be blocking the individual from coping better with job related stress? a.) at work: B felt the hospital was understaffed, adding to her stress.

b.) in herself: B found she sometimes dwells on a situation too much, thinking about it until it upsets her.

c.) in others: B found her family did not want to listen to her discuss work or anything work related. She felt that her family blocked her coping by not being supportive of her; because of this, she often said nothing to them if something really bothered her. B gets angry when she thinks about her family not understanding nor being sympathetic.

What may help the individual to deal better with job related stress?

a.) at work: B feels the resources at the hospital are excellent (psychologists, pastors, other nurses, a coping workshop), but feels there is a need for more stress management or coping workshops.

b.) in herself: B feels it would help her to cope better with her stress if she were more active physically and attended more stress management workshops.

c.) in others: It would help B if her family asked her how she was doing with her work at the hospital. Also, B felt it would be helpful if staff asked how she was doing other than at times when she was upset or depressed. However, that was something she does not do for the other nurses.

Coping resources. a.) social supports: other staff, girlfriends.

b.) health/energy/morale: B takes good care of her physical health, especially since she began work at the Cross.

c.) utilitarian resources: pastor, psychologists, a coping workshop.

d.) general and specific beliefs: The first month B worked at the hospital, she found the work extremely stressful; however, she had faith in her intelligence and capabilities and knew she would get over this stress. Without this belief, she feels she likely would not have remained at the hospital. It was very important for her to have faith in her skills and in herself.

e.) problem-solving skills: B illustrated the use of this resource in situation 3 (her strategy of reorganizing herself to do the important duties first).

"Felt" effectiveness of coping strategies overall. B felt she coped quite well with her stress overall in the past, however, she had been dreaming a great deal about the hospital over the three weeks prior to the interview and was not sure how well she was coping with her stress at the time of the interview. B knows she has coped effectively with her stress when she feels good inside herself, sleeps better and doesn't remember her dreams.

Enough strategies for coping with stress? B felt she had enough strategies for coping with stress, but that she may not use them as much as she should.

Comments. B found the interview process comfortable and was interested in the results of the study.

Summary. B felt that she had coped well with her stress in the past, but was not sure how well she was coping at the time of the interview, due to her numerous dreams about patients and a feeling of foreboding (that she was going to have an accident and die). One type of stress B stated she had difficulty coping with was that painful stress from losing someone close to her. She has found she can't discuss these feelings with anyone and feels burdened by the number of deaths she encounters at work. B has found that she has a harder time of dealing with deaths outside the work environment: "why do I have to be burdened with people outside of the hospital dying?" Death is a stressful event for B; it seems to be an area where she could use some additional coping strategies.

Subject C

Works full time, has 1 - 5 years nursing experience and has been a ward nurse for 13 - 24 months.

Coping strategies identified when dealing with stress generally. C identified the following stress indicators: focusing primarily on her job (working hard physically and not communicating well with her patients); frustration; crying (but not sure why); her stomach feeling like it's in knots; cramps; diarrhea; headaches; loss of appetite; and dreams about patients.

C described coping with stress as being able to go to work and meet all of the demands without falling apart under the pressures. C uses many different strategies for coping with stress: telling herself to slow down and talk with her patients; talking with her roommate or boyfriend; going for breaks with other staff and getting help and support from them; talking with her family; having long periods of time off between shifts; putting work out of her mind; and getting involved in something physical (swimming, running, aerobics) and social activities: "you have to [work the pressure off] otherwise you wouldn't be able to come back [to work]."

Situational examples.

Situation 1. C found a similar situation very stressful, because she related it to herself. She felt frustrated (at the lack of help the chemotherapy might give and at the patient for being so ill and not noticing disease symptoms earlier), helpless and angry. She also felt scared; often when people talk to C about dying and they know they are dying, she is unsure how to deal with it. She has trouble imagining the patient's feelings and sharing her own feelings and wonders about her own mortality. C feels that people who are dying have been cheated and that their suffering is unfair: "Those poor people, how come they have to suffer like that, and it's hard for me to watch them..."

C discussed several different ways for her to cope with her stress: talking with the other nurses and the patient's family; spending time with the patient, doing as much for him as she can; sometimes trying to 'shut' herself out as she doesn't want to 'see' everything that is happening to the patient (disconnecting herself emotionally); and at home, putting her feet up, having a drink and talking with her roommate or boyfriend to get verification that she did the 'right' thing for the patient.

Some days C finds she copes effectively with this stress and other days, she goes home "feeling really the pits", especially if she feels she hasn't helped the patient or family. When the patient dies, C finds it helpful to get together with other staff and share her thoughts and feelings: "You just can't hold all of these things in, you have to share them with other people and tell them what you think..."

Situation 2. C would find this situation stressful and would feel helpless, frustrated and angry.

To help herself to cope with her stress, she would think of ways to help the patient. C feels good when a patient is no longer suffering. She might also talk to the other nurses to vent her feelings.

If C cannot get the patient comfortable, then she finds she doesn't cope as effectively with her stress. C sometimes gets angry with herself as she feels she loses her patience too quickly when she wants to get something done for a patient and it seems to her that no one else seems to care about the patient but her.

Situation 3. C found this situation to be a very real and stressful one. She would feel helpless and, if she was unable to stay with the distraught patient, she would feel guilty and neglectful.

To cope with her stress, C would sit with the patient or get someone else to be with the patient if she couldn't stay.

This is a fairly effective way for C to cope with her stress, but she sometimes feels that she is brushing the situation aside and wishes she could do more for the patient.

Situation 4. This would be stressful for C. She would feel hurt (because she would be trying her best to help the patient) and guilty (at not being able to insert the catheter).

To cope with her stressful feelings, C might: leave the room and cry; talk with another nurse for moral support and practical help; and try to consider the family's perspective and perhaps talk with them.

Crying and getting support are effective ways for C to cope with her stress; these strategies help her to deal with her hurt feelings, see the family's perspective and help her to deal with the family.

Situation 5. This would be a stressful situation for C, but not as stressful as situation 4. She would feel scared (at the doctor's anger) and defensive.

To cope with her stress, C might: talk with the doctor to explain the situation and talk with the other nurses to check out the situation.

C was uncertain how effective these coping strategies would be, because she feels intimidated by physicians.

What may block the individual from coping better with job related stress? a.) at work: nothing.

b.) in herself: C tends to put off dealing with her stress by emotionally shutting herself out of what is happening. She has trouble coping with death and dying because of the pain for the patient and for the family, so she tries to avoid it.

c.) in others: nothing.

What may help the individual to cope better with job related stress?

a.) at work: C felt it would help her to deal with her stress if there were more meetings for the staff to deal with and share their feelings after the death of a patient. C finds being close to other staff members helps her to cope with her stress at work; support services is helpful as well. C added that she thought more staff would help.

b.) in herself: C would like to confront stressful situations more easily rather than putting them off. She would also like to be more honest with patients when talking about dying, but she is afraid of hurting them; her ambivalence in these situations is stressful for her.

c.) in others: C would like more ideas from others on how to deal with the family of a dying patient. She would also like to get more positive feedback for her work: "Sometimes I think it gets missed a lot here because everybody is really busy and you know, we're all trying our best and you miss that. And it's really nice when it comes from the family or patients."

Coping resources. a.) social supports: staff, roommate, boyfriend, family.

b.) health/energy/morale: Staying healthy, being physically active. C finds after four - twelve hour shifts that she feels tired, depressed and "a little burnt out". Being active seems to help.

c.) utilitarian resources: support services, amount of time off after a four day shift.

d.) general and specific beliefs: C turns to God and religion when she feels there is no one else she can talk with and to help her deal with death.

e.) problem-solving skills: C discussed different ways of getting the patient comfortable in situation 2, illustrating problem-solving skills.

"Felt" effectiveness of coping strategies overall. C feels that sometimes she deals well with her stress, and at other times, she doesn't. Toward the end of four-twelve hour days, she finds she is depressed, tired and "a little burnt out." Having time off between shifts helps her to get over these feelings. C knows she has coped effectively when she feels "better inside": "If I cry or talk to somebody about it, it makes me feel better and I don't feel as restless and uptight and like clenching my fists and going around mad." She feels calm and at peace with herself and feels okay about going to work the next day.

Enough strategies for coping with stress? C feels that she has enough strategies for coping with stress: "It works all right for me."

Comments. C stated: "The only thing that really is important about the way ... the reason why nurses here cope with stress I think as well as we do is that we are all very close to each other and we really help each other out. I think the staff here are just great."

Summary. C feels she copes well with stress, though has some days where she doesn't feel she copes well at all. C seems to have difficulty dealing with death and dying, which gives her quite a bit of stress. For C, dealing with her stress often means finding a solution to the stressful situation; if the problem is not solved, C doesn't cope as effectively with her stress as when it is solved. Support from the other nurses and the sharing of feelings are very important to C when dealing with stress at work.

Subject D

Works full time, has 1 - 5 years nursing experience and has been a ward nurse for 25+ months.

Coping strategies identified when dealing with stress generally. D finds "nursing is a very stressful field at the Cross because there is a lot of death involved, a lot of family involvement when the patient dies ..." D has the following stress indicators: mood swings; unable to relax or fall asleep, but when she does, she sleeps for longer periods of time; depression; irritability and loss of patience with her children more easily; her face breaks out; smoking increases; and may eat more or have no appetite at all.

D described coping with stress as being able to define the stress and deal with it before getting into a really stressful situation. D tries to cope with a stressful situation before the stress indicators start, e.g. she may try to prepare herself for the death of a patient before it happens. D copes with stress in many different ways: through physical exercise; discussing concerns with a good friend; not dwelling on the problems at the hospital; using her sense of humor; walking, driving, reading or singing; crying; and socializing with friends who are not connected to the hospital. D shared a coping mechanism she used that scared her; after the death of a certain patient, she got drunk as she was unable to share her feelings about the death with anyone. It bothered her that she used alcohol to cope and she was concerned that she might use it again. D cried while talking about this situation.

Situational examples.

Situation 1. D would not find this situation stressful. She talked about a similar situation where she felt sympathy for the patient and family, but the quickness of the death did not let the situation affect D that deeply. She finds she is more disturbed by long term patients as she becomes more emotionally connected to them.

Situation 2. D would find this situation stressful and would feel frustration and question the situation.

To cope with her feelings of stress, D might: pray; ask for more medication; and try to do things for the patient.

She finds she copes effectively with her stress in these ways because she feels useful and proud that she can help the patient.

Situation 3. This situation would be stressful for D as she would feel frustrated.

To deal with her frustration, she would talk to the head nurse to get help and get someone from volunteer services to sit with the patient.

These would be effective ways for D to cope with her stress as she feels it is all she can do; it helps her to be able to take some action to change the situation.

Situation 4. D felt this situation would not be stressful as she wouldn't let it get to the point described in the situation. To prevent this, D would get more information from the doctor to pass on to the family; talk with the family to get them more involved; and talk with the patient. It is effective for D to cope with the situation in this way before it gets really stressful.

Situation 5. D would find this situation very stressful. She would feel angry, inferior, defensive and hurt.

The coping strategies D might try would be: to go over the situation again to defend herself and deal with it so she will be able to face the doctor again; talk with her co-workers to see how they would have dealt with it; and perhaps cry.

These would help her to cope effectively with her stress.

What may be blocking the individual from coping better with job related stress? a.) at work: The busy nature of the hospital sometimes causes her to put aside coping with her own stress.

b.) in herself: D feels that because she thinks of herself as strong, that she blocks out her feelings rather than deal with them.

Also, she finds she sometimes doesn't have the time to cope with her stress.

c.) in others: Others block D from coping with her stress by not listening when she needs to talk about her job related stress.

What may help the individual to deal better with job related stress? a.) at work: D would like: a place in the hospital where the nurses could meet and talk together (a nurses' lounge); fitness programs available at different times so more nurses could participate; and an opportunity every two or three months to talk with other nurses about how they are coping with stress (D feels this would help her to cope better). D commented on help being available from the psychologists at the hospital and that she was planning on taking a stress management workshop.

b.) in herself: Talking to someone (D suggested a psychiatrist) about things that really bother her and that she finds hard to discuss.

c.) in others: Others could help D more by being willing to listen when she is feeling stress from work.

Coping resources. a.) social supports: friends, co-workers.

b.) health/energy/morale: D keeps fit by exercising, using it to work out her stress. She likes working at the Cross, because she feels useful and special by working there.

c.) utilitarian resources: D finds the activities of daily living and being able to get away (due to the number of days off between shifts) help her to cope with her stress. Also, she is aware of help being available from the psychologists at the hospital and will be attending a stress workshop.

d.) general and specific beliefs: There was no clear indication of the belief systems D uses.

e.) problem-solving skills: This resource was illustrated in D's discussion of how she would cope in the situational examples, particularly situation 4.

"Felt" effectiveness of coping strategies overall. D feels she copes fairly effectively overall. She knows she has coped effectively with her stress when she can take life as it comes, laugh spontaneously, enjoy family and friends without work on her mind and not think about work on her days off.

Enough strategies for coping with stress? D feels she has enough strategies.

Comments. D admitted to be still working on some painful feelings regarding one patient's death. She found the interview to be good and wanted to know the results.

Summary. D finds her overall effectiveness in coping with stress to be good, but is still dealing with feelings related to the death of a particular patient. She expressed a great deal of concern over her use of alcohol in coping with her stressful feelings resulting from this death and the possibility that she might use alcohol again.
D plans on taking an upcoming stress management workshop.

Subject E

Works full time, has 5+ years nursing experience and has been a ward nurse for between 3 - 12 months.

Coping strategies identified when dealing with stress generally. When E is stressed, she has the following stress indicators: crabbiness at home; getting cross with patients; losing her temper for no apparent reason; chest pains; and tearfulness. If E is feeling very stressed, she does not sleep well and may eat more than usual.

E described coping with stress as being able to manage your workload without undue anxiety and feeling at ease with yourself. E uses many different strategies to cope with stress: taking time by herself; crying; trying to pinpoint what is bothering her; praying; sleeping; going for a walk; and talking with someone else to try and understand how she's feeling. E finds the other staff to be very supportive and perceptive of her feelings. E spoke of the stress she feels being in a relatively new job: wondering if it's for her; feeling isolated; and wondering if she can learn everything she needs to.

Situational examples.

Situation 1. E would find this situation stressful; it brought tears to her eyes during the interview. She would feel sorry for the patient, anxiety (over his need for more time and the treatment), sadness, inadequacy and frustration.

To cope with her feelings, E might: try to do something that would make her happy so she could forget the situation and put herself back in perspective (go out with her husband, with friends); pray for the patient; or disconnect herself from the situation: "I think I tend to put a little shell around myself quite often."

E feels she copes effectively with the stress in this type of situation, but sometimes feels guilty when she compares the patient's luck with her own. She uses "defense mechanisms" (the shell) to protect herself at work and does not tend to take her work home with her.

Situation 2. This would not be very stressful for E; it might eventually get to her over the long term. She interpreted the described individual to be old, and therefore, would find this less stressful than if it was a young person. E would feel that it was likely that patient's time to die (no other hope but death) and the patient's desire and readiness to die would make it less stressful as well. E would not want to care for this patient everyday, to protect herself from stress.

Situation 3. E would find this stressful due to the time limits and pressures. She would feel anxious, angry (about getting such a busy assignment) and impatient.

To cope with her stress in this situation, E might: talk with the team leader to get her assignment changed; get a volunteer to sit with the distraught patient; or explain the situation to the distraught patient and spend time with her when the other work is done.

These would be effective and comfortable ways for E to deal with her stress: "Once you feel that responsibility off of you, then I wouldn't feel as stressful." E believes it is her professional responsibility to acknowledge when she cannot handle something.

Situation 4. This situation would be stressful for E. She would feel frustrated (being unable to catheterize the patient and by not communicating with the family).

Coping strategies E thought of were: getting someone else assigned to work with the family; talking with the family and explaining the situation; and trying to take the family's perspective. This would be a most stressful situation for E because the family was cold and withdrawn; she would feel better if she was able to communicate with the family and if they were more accepting of her. She might feel like a failure if she was unable to get through to them, but "you can't win them all."

Situation 5. This situation might be temporarily stressful for

E, but she wouldn't worry about it too much. She might feel disappointed and hurt for awhile.

To cope with these feelings, E would feel that she was not completely responsible for the situation and think that the patient was likely well looked after. She would try to rationalize why the doctor was angry and try to keep the situation in perspective.

These would be effective ways for E to cope with the stress in this situation.

What may be blocking the individual from coping better with job related stress? a.) at work: E finds a lack of continuity in patient assignment and finds this stressful. She has found she has not always been made aware of responsibilities, but feels this may be because she is new.

b.) in herself: Not getting enough sleep.

c.) in others: E finds people who are uncooperative, impatient and uncaring block her in coping with stress.

What may help the individual to cope better with job related stress? a.) at work: Having the time and place to study patient charts.

b.) in herself: E could help herself to cope better if she came to work earlier to look over her patient assignment for the day. Also, by studying more and becoming better informed about oncology. E feels she needs to make an effort to do things that would help her.

c.) in others: Others could help E cope better if those with a lighter workload would help her when she has a heavier workload and if other nurses would more readily pass on information that she needs to know about hospital policy, procedure, etc.

Coping resources. a.) social supports: family, friends, other staff, team leaders, patients.

b.) health/energy/morale: Getting enough sleep.

c.) utilitarian resources: support services, interns, supervisors, volunteer services.

d.) general and specific beliefs: E's perspective is optimistic: "If a day is bad, things won't always be that way." Also, her religious beliefs help her to cope with her stress as she believes in life after death and that it is God's will when someone dies. She also feels confident in herself and in her abilities as a nurse.

e.) problem-solving skills: These were not really illustrated by E as a resource.

- "Felt" effectiveness of coping strategies overall. E feels she copes very well with work related stress. She doesn't find her job to be high pressure, though it is fairly stressful due to the contact with the terminally ill. It is more stressful when there are many deaths occurring over a short period of time. However, E finds her home life to be more stressful than work.

E knows she has coped effectively when she feels good and the pressure and tension are reduced. Sometimes, it takes time for her stress indicators to ease; she occasionally needs a change of environment or to do something completely different to get her mind off of stress.

Enough strategies for coping with stress? E answered this question yes and no. She is open to getting more ideas on how to cope more effectively with stress, but feels she has tried to eliminate from her life that which stresses her and has built up coping mechanisms to deal with stress.

Comments. E found it hard to answer questions on how she felt and what she did about those feelings in some situations. She found the interview to be well organized, but wondered about letting the subjects have the questions ahead of time so that they might give fuller answers.

Summary. E finds she copes more effectively with her job related stress, but is open to learning more strategies. She has not yet experienced having any patients die that she is close to and was unsure how this would affect her. Her optimistic outlook and religious beliefs are very important in helping her cope with stress.

Subject F

Works full time, has 5+ years nursing experience and has been a ward nurse for 13 - 24 months.

Coping strategies identified when dealing with stress generally. When F is feeling stressed, she had the following indicators: gets cranky easily at work and at home; feels a need to be on her own; may become more sensitive (cries more easily); may not be able to sleep; and may eat or smoke more.

F thought of coping with stress as finding means to deal with a particular problem. Coping strategies she uses are: talking with her roommate; spending time alone; going out shopping; and talking with other staff. F tries to prevent feeling stressed by not getting too emotionally involved with her patients ("You last longer if you stay less involved") and by not taking her work home with her.

Situational examples.

Situation 1. This would be a very stressful situation for F, if she had been dealing with the patient since admission. She would feel very sorry for the patient and his family and feel sad.

F wasn't sure what she would do to cope with her stress; she thought that she might do nothing, just let it pass and forget about it.

F was unable to answer how effectively she felt she coped with her stress in this type of situation.

Situation 2. This is not stressful for F. Since the patient is ready to die and she is suffering, F feels that it would be better for the patient and the family when she does die. F would find it more stressful if the patient was a younger person.

Situation 3. F would find this situation very stressful, feeling mainly panic.

She would ask for help from the other staff so that she could sit with the distraught patient.

If she got help and was able to sit with the patient, she would find this an effective way for her to deal with her feelings of panic and would feel good coping this way.

Situation 4. F would find this stressful because of the family's lack of confidence in her. F thought she might feel: defensive, angry and sorry for herself.

The coping strategies F might use are: crying alone in the bathroom; talking with the other staff, the family and the physician; and trying to understand the family's perspective. F found it hard to know what she would do: "The questions are very hard."

Talking about the situation would be an effective way for F to deal with her stress.

Situation 5. F would find this situation stressful due to the doctor's lack of confidence in her. She might feel: resentment and guilt and wonder about her actions in the situation.

F had difficulty thinking of how she might feel in this situation and was not sure how she would cope with her stress.

What may be blocking the individual from coping better with job related stress? a.) at work: nothing.

b.) in herself: F finds she may deny to herself that she is feeling stress.

c.) in others: When others do not listen or try to understand the situations she has encountered.

What may help the individual to deal better with job related stress? a.) at work: F felt that having more stress management workshops and more discussions with the psychologists would be helpful.

b.) in herself: Attending more stress management workshops. F was planning to attend a stress management workshop that was being offered as she had found she was feeling more stress. She felt this was due to the longer she worked at the hospital, the more she got to know her patients and the more attached she became to them.

c.) in others: Listening and being supportive.

Coping resources. a.) social supports: staff, roommate, supervisors, psychologists, priest, friends and relatives.

b.) health/energy/morale:. The use of this resource was not really illustrated.

c.) utilitarian resources: psychologists, workshops, doctors.

d.) general and specific beliefs: F's religious beliefs were very important to her; she believes that it is God's will when someone suffers or dies. Also, she feels she has a high degree of self confidence.

e.) problem-solving skills: This resource was not really illustrated.

"Felt" effectiveness of coping strategies overall. F felt she coped not too badly with her stress. However, her stress seems to be less easily dealt with the longer she is in her job.

She knows she has coped effectively when she is no longer cranky, is more talkative and social, and feels happier.

Enough strategies for coping with stress? F admitted that she may need more coping strategies.

Comments. F stated she felt better by talking about stress and coping with the interviewer. She felt her feelings were brought forward in the interview and she was interested in the results.

Summary. F seemed to be at a point where she was having more difficulty dealing with job related stress than perhaps a year ago. Though she felt her feelings were brought forward in the interview, she had some difficulty verbalizing her stressful feelings in specific situations and how she coped with them. F wanted to learn more about stress management and was planning on attending a workshop on this.

Subject G

Works full time, has 5+ years nursing experience and has been a ward nurse for 25+ months.

Coping strategies identified when dealing with stress generally. G had the following stress indicators: short temper with husband and staff; chain smoking; moving around very quickly; not sleeping well; and feeling the need for a "good, long cry."

G described coping with stress as finding ways to deal with a bad situation, to make it more bearable. She had many coping strategies:

talking with other staff; having time by herself; losing her temper; talking with her husband and sharing her feelings with him; and getting involved socially (may get drunk).

Situational examples.

Situation 1. G would find this to be a stressful, awful situation, especially with a young patient. She would feel frustrated and sad (due to his young age, the way he died and his inability to achieve spiritual peace).

To cope with her stress, G might: rationalize his death ("some people die young and don't die 'nice' deaths"); consider her own spiritual beliefs; make the patient as comfortable as possible; talk with other staff; and accept that "sometimes life is very unfair", so that she doesn't expend much energy debating that within herself.

G feels that she copes effectively with this type of stress: "What happens happens and there is usually very little anyone can do about it."

Situation 2. G would find this very stressful. She would feel frustration, anger and helplessness (not being able to do enough for the patient).

To help her to cope with her stress, G would try to get the family involved in patient care (this helps to take the stress off of her); get the medications increased and try to do things to distract the patient from her pain; get spelled off by another nurse until she can deal with the situation again; try to give as good nursing care as possible; and have faith that it will all eventually come to an end (a belief in a better life after death).

G feels she copes fairly well with this stress, but finds it trying until the patient is comfortable. G wondered if she might be able to cope better with the stress in this situation, "... but it all seems to work out in the end."

Situation 3. This would be a stressful situation for G. She would feel frustrated (at having so much work to do) and guilty (if she was unable to sit with the distraught patient).

To deal with her own stress, G would: have a psychologist talk with the patient; organize herself according to the time needed and know when she had to do things; and take care of the technical demands first.

She finds these strategies to be effective as she always tries to be organized and aware of what is going on; she feels good coping in this way if the patient is taken care of.

Situation 4. G would find this stressful. She would feel frustrated and angry (with the son for not understanding).

To help herself cope with the stress, she would: try to see the situation from the family's perspective and try to talk with the family; talk with the other nurses in an attempt to figure out how to deal with the problem; get other nurses to work with the family as well; and think of how she has dealt with other difficult families and think of the positive feedback she has gotten from other patients.

Coping with her stress in these ways is not totally effective, but it helps her anger to subside to a "comfortable level." G feels reasonably good coping in these ways, but feels it could be better since it is quite stressful for her.

Situation 5. G would find this situation very stressful. She would feel angry (being spoken to in that way).

To cope with her stress, G would: try to consider the doctor's perspective (see herself as a scapegoat or sounding board); confront the doctor and try to discuss it with him; see it as the doctor's problem, if talking with him does not help, and not take it personally; and talk with her supervisor.

G felt this was one of the stressful situations she copes with better; she would get angry briefly and then it would go.

What may be blocking the individual from coping better with job related stress? a.) at work: She feels the work situation is fairly good, as she can talk with several people in the administration, who seem to be aware of the stress on the wards. However, she feels there is not enough staff.

b.) in herself: Having a short temper.

c.) in others: G finds the nursing staff good to work with, but finds having new graduates on the floor stressful as she has to teach them as well as attend to her own duties.

What may help the individual to cope better with job related stress? a.) at work: G would like to have stress management seminars more often as she feels she could use some new ideas. If more seminars were held, she would like to see them at different times, so that different shifts could take advantage of them.

b.) in herself: G would like to be less short tempered and would also like to be more aware of her own needs rather than waiting to take care of herself until she has a bad headache.

c.) in others: nothing.

Coping resources. a.) social supports: husband, other nurses, friends.

b.) health/energy/morale: G uses herself as a resource: "Knowing where your failings are, what causes stress within you and what makes it go away." G uses her quiet time alone to restore her energy.

c.) utilitarian resources: psychologists, supervisors, doctors.

d.) general and specific beliefs: G is not a member of a particular religious faith, but her beliefs in God and a good hereafter help her to deal with the stress from someone's suffering. Also, her faith in herself helps her to cope with stress.

e.) problem-solving skills: This resource was illustrated in how G coped with stress in situations 2, 3, 4, and 5.

"Felt" effectiveness of coping strategies overall. "I think I must deal with it quite well because I am still at the Cross." Times when G is not coping well with the stress are when she needs her quiet time.

G knows she has coped effectively with her stress when she feels good about herself and others, wants to be involved with others and is not chain smoking nor feeling "hyper" (like moving around a lot).

Enough strategies for coping with stress? "I think everyone could always use more." G finds when someone close to her dies, she has difficulty dealing with her feelings; she sometimes cries with the family and she wondered if this was a failing.

Comments. G found it helpful to think about what she did with her stress and the results made her feel good. She was curious about how other people cope.

Summary. G generally feels good about the ways she copes with her stress, but would like to consider some new ways. One area of stress G has difficulty in dealing with and is concerned about is how she copes with the death of someone she feels close to. Her husband and the time she spends on her own are important resources for G; she also finds herself to be an important resource in coping.

Subject H

Works part time, has 0 - 1 year nursing experience and has been a ward nurse for 3 - 12 months.

Coping strategies identified when dealing with stress generally. When H is feeling stressed, she has the following indicators: grumpiness; "tension" headaches; feedback from her husband and children that she is acting stressed; and her sleep pattern is disturbed (H has not slept well since beginning work at the Cross, but feels this has more to do with being a new graduate than with the work environment specifically).

H described coping with stress as "how you handle it stress , how you get by in your day to day existence." Coping strategies she uses are: crying ("this is a good release"); getting quieter and reflecting upon her feelings; talking with former classmates and other nursing staff; working part time; and having an active home and social life. She also reads the obituaries before going to work so that she can deal with the feelings she might have over the death of a patient at home, emotionally preparing herself before going to work. The availability of support from the staff members and the hospital chaplain or psychologists also help H to cope with stress.

Situational examples.

Situation 1. H would find this situation stressful, feeling anger (due to the patient's age, she would identify him with her own children), sadness (for the family) and helplessness (due to the quickness of the patient's deterioration and her inability to do anything about it).

H would have coped with her stressful feelings by: perhaps separating herself from the situation (unless she was the 'special' nurse); and by focusing her attention on other duties: "It's not hard to lose yourself in your work." She doubts that she would have been personally involved in this type of situation, due to the quickness of the illness and so, would find it easier to detach herself emotionally. H did not think her stressful feelings would last long.

Separating herself from the situation or focusing on other duties are effective and easy ways for H to cope with stress. H finds she is still learning a lot of material and there is much to take her attention. If her feelings remain after coping as described above, H may cope with them by: crying; reading (H mentioned books by Kubler-Ross); or by trying to justify or rationalize the death.

In an actual situation recalled by H, where a patient's death upset the nurses on that floor to the point where they were unable to support each other, a staff psychologist and a doctor spoke to the nurses to help them to cope with the death. H found this helped her to cope with her stress that resulted from that patient's death.

Situation 2. H would find this situation stressful. She would feel frustrated and helpless (due to the patient's distress and also, if the patient's life were prolonged by "heroic efforts").

To deal with the stress in this situation, H might: discuss her feelings with other staff; and bring in volunteer services to help if she was unable to stay with the patient.

Talking with other staff is an effective way for H to cope with the stress she would feel; she learns from the other staff and can also vent her feelings with them. This is a comfortable way for H to cope and she seeks out people who are similar to her ("quiet disposition") and cope in a similar way.

Situation 3. H stated that this situation was realistic and that she would find it stressful. She would feel totally frustrated (due to the many demands placed upon her).

To cope with her feelings of frustration, H would get help with the physical demands, so she could sit with the distraught patient or get other patients to support this patient.

H feels all right utilizing other resources to help her to cope with her stress, but would still likely feel frustrated when she left work: "... but [I realize I] can only do so much." H is learning her limitations and feels that with experience will come the ability to set priorities and do things more quickly, which will lessen her frustration. She is not totally satisfied with the way she copes with this situation, but tells herself "things will improve." She finds it helps to know that other recent graduates encounter similar problems. Also, things are improving: "I mean our first month, if we had two good days out of twenty, it was time to go out and celebrate... it really was, you know and now the good days are more than the bad."

Situation 4. H would have found this situation stressful, feeling nervous (having to perform the task in front of the family), angry, and frustrated.

To cope with her stress, H might: try to take the family's perspective (believing they are misdirecting their feelings about what is happening to their loved one onto her); assert herself and discuss the situation with the family; and get help from the other staff (for information purposes, moral support and to confirm her judgement and actions). If H still felt angry later, she might cry.

She finds these strategies to be effective ways for her to deal with her stress. She took an assertiveness training course to help herself cope.

Situation 5. H has not encountered this type of situation in her time as a nurse and found it hard to envision how she might cope with any stress that might come from that situation. She thought that it would likely be stressful and that she might feel defensive, but was not sure of what coping strategies she might use.

What may be blocking the individual from coping better with job related stress? a.) at work: H feels that, because she is a recent graduate, she needs more feedback from her head nurse as she is not certain of how she is doing. H thinks that she is performing her duties well, but is anxious to have that confirmed. Having this feedback would help H to feel more confident and cope better.

Another block for H is that she would like to attend more workshops/inservices, but does not feel she can leave the ward to attend during work hours, in case she burdens the other staff.

b.) in herself: Getting overly involved, emotionally, with her patients.

c.) in others: H believes the lack of feedback she gets from other staff may block her and cause more stress.

What may help the individual to cope better with job related stress? a.) at work: H feels stress due to the exposure to "hot" patients (patients who have recently undergone radiation treatment) and would like some change in procedure to lessen this exposure. Overall, H felt the hospital was a good, supportive place to work. However, she also feels it is short staffed, though stated it was better staffed than other hospitals.

b.) in herself: Learning more and become more experienced in cancer nursing. Also, getting less emotionally involved with the patients.

c.) in others: Getting more feedback from other staff members.

Coping resources. a.) social supports: friends, classmates, hospital chaplain, own minister. H does not use her husband as a resource for coping with job related stress as he only wants to hear happy things. While the staff is generally supportive, H does not feel much connection with them; she feels this is due to working part time and working different shifts on different floors. However, H often feels a connectedness with the patients and their families and finds she gains a lot from them.

b.) health/energy/morale: H finds it easier to cope with her stress on the first day of her shift as compared to the last day; she finds she copes less well when she is tired. Also, she finds she copes better when her home life is going well and her husband is not out of town.

c.) utilitarian resources: inservices, workshops, volunteer services, psychologists, hospital chaplain.

d.) general and specific beliefs: H believes that things will improve for her in her work and that she will learn to cope more effectively as time goes on.

e.) problem-solving skills: Problem solving skills were not really illustrated.

"Felt" effectiveness of coping strategies overall. H feels that she copes well with the stress she encounters at work, but sometimes "falls apart at home", venting her feelings on her family. She feels that much of her stress comes from being a new graduate and that it will lessen as she becomes more aware of her own limitations. H knows she has coped well with stress when she no longer has "churning, uptight feelings" and feels good.

Enough strategies for coping with stress? H believes that she has enough strategies for coping with stress and that she will cope better with more nursing experience.

Comments. H wanted to know the results of the study. She found some of the situations that were presented to be quite realistic. H believes that the stress situation at the Cross is different from the stress encountered by other nurses in general, because there is so much support available at the Cross.

Summary. H seemed to feel much stress from being a new graduate and found that she is often coping with new learnings. She found that as she gained experience, she had more "good days" at work. H felt that she coped well with stress while at work, but at times, brought it home and vented it on her family. She felt that she will cope better as she learns her limitations and gains more experience.

Subject J

Works part time, has 1 - 5 years nursing experience and has been a ward nurse for 3 - 12 months.

Coping strategies identified when dealing with stress generally. When J is stressed, she: gets frustrated and wonders how she is going to get everything done; may be in a bad mood; may get leg or head aches; and may cry.

For J, coping with stress is the manner in which you deal with the situation: "Your solution to the problem." Coping strategies used by J are: resting or sleeping; crying; talking with someone (husband, other nurses); getting out of the situation if it is too stressful; going for a walk or a drive; changing her patient assignment; and taking a break (going for her coffee break early).

Situational examples.

Situation 1. This would not be stressful for J, as it happens often and she finds that it is not as bad as when patients linger. Also, since the patient didn't suffer very long and died elsewhere, she likely would not have had time to develop a relationship with him.

Situation 2. This situation would be stressful for J because the patient wanted to die (and J could not help her) and was not pain free. J would feel mostly frustration.

To cope with her stress, J would: seek different ways to comfort the patient; get the family involved in the patient's care; and help the patient understand why she's in pain. J finds that good communication with the family and the patient helps to relieve her frustration and therefore, the stress in the situation. She recalled a situation where the family did not trust the nurses; J did not feel she coped well with her stress in this situation, because she did not know what to do. She finds that she detaches herself from a family and stays at a professional level if she cannot connect with them.

It's harder for J to cope with the stress in a situation by detaching herself emotionally. She feels better if she can work with the patient and the family and have open communication and cooperation. J avoids dying patients she does not know or uses a cool, professional approach with them.

Situation 3. J would find this situation stressful due to the time demands. She would feel angry and frustrated.

Strategies that J might use to cope with her stress are: getting a volunteer to sit with the distraught patient or another nurse who has free time; talk with another nurse or her husband; and just say to herself "it's a bad day," keep working and forget about her stress.

J finds trying to forget about her stress effective as long as she isn't faced with the same situation day after day. She has come to expect the occasional bad day. Forgetting about a situation isn't her favorite way to cope, but she finds it works over the short term until she can do something else. If the situation is happening day after day, talking with her husband and having days off help.

Situation 4. J has not had this situation happen, but thought it would be stressful for her. She would feel: frustrated (because she would want to help); angry (because she would be trying her best and the family wouldn't understand); blamed; and like a failure.

To cope with her stress, J might: talk with the son to try and work out things; talk with her husband; talk with the other nurses to build up her morale (so she doesn't feel like a terrible nurse); think of other situations where she has done a good job; or change patient assignment.

J would find this situation hard to deal with; she felt she should talk with the son, but likely would not want to. Talking with others would help to build up her morale.

Situation 5. J has not experienced this situation. She felt it might be immediately stressful (as she would be taken off guard) and she would likely feel shocked by the doctor's behavior.

J would not take the situation seriously and would see it as the doctor's problem. She felt this would be an easy way for her to cope with her stress, since it would not be her problem.

What may be blocking the individual from coping better with job related stress? a.) at work: nothing; J finds much support and understanding for the stress the nurses encounter.

b.) in herself: Not dealing with the source of stress.

c.) in others: nothing.

What may help the individual to deal better with the job related stress? a.) at work: nothing.

b.) in herself: J would like to be able to cope with the source of stress immediately and get rid of it before she gets stress indicators like headaches. J would also like to become more aware of her initial stress indicators; she finds sometimes when she is not coping with her stress, a minor incident will cause her to cry and feel depressed. At these times, she realizes she hasn't been dealing with her stress and may be blaming others for how she is feeling.

c.) in others: nothing.

Coping resources. a.) social supports: husband, other nurses, friends, patients and their families, her own family.

b.) health/energy/morale: Getting positive feedback from others is important in helping J cope with her stress (use of other nurses in situation 4 to build her morale). Getting ten hours of sleep before going to work helps J to stay healthy and cope more easily.

c.) utilitarian resources: working part time, doctors, head nurses, volunteer services.

d.) general and specific beliefs: Religion is very important to J; she feels her religion helps her to understand patients and death, as her beliefs are well worked out.

e.) problem-solving skills: J tries to organize herself and her time, so she does not need to think about work when at home nor home when at work. She likes to plan so her life runs smoothly; planning for or expecting a stressful day at work helps her to cope with it.

"Felt" effectiveness of coping strategies overall. J thinks that she is average in her ability to cope with stress. Sometimes she feels that she copes really well and at other times she doesn't; she believes that she copes more than she doesn't cope. J can cope better with expected stress than with the unexpected stress.

When she has coped effectively with her stress, J feels good inside and competent, enjoys going to work and doesn't feel tired and uptight.

Enough strategies for coping with stress? J thinks she has enough strategies for coping with stress and knows what to do to cope, but doesn't always do it. J finds if a strategy works, then it's effective. She used to feel guilty using sleep to cope with stress, but now feels good about using it. It has helped J to be accepting of how she copes with her stress.

Comments. J felt the interview was good as it helped her to think about what she does do with her stress. She found the interview process comprehensive, interesting and enjoyable.

Summary. J felt she coped with stress with average effectiveness. For J, it was important for her to accept how she coped with her stress. She would like to be more aware of her own stress signals to prevent more severe stress symptoms, such as stress headaches. Her religious beliefs were very important in helping her to cope with stress.

Subject K

Works part time, has 1 - 5 years nursing experience and has been a ward nurse for 13 - 24 months.

Coping strategies identified when dealing with stress generally. K has the following stress indicators: short temperedness; talking fast; moving around a lot; taking her feelings out on others; and waking up in the middle of the night and being unable to go back to sleep.

For K, coping with stress is being able to handle a situation or discuss the problem with the individual. To cope with her stress, K might: write letters when she can't sleep; work harder around her home; bake; go shopping or to a friend's house; talk with other nurses or to her husband; pray and believe that everything will work out all right.

Situational examples.

Situation 1. The stress in this situation for K is caused by the patient's need to prepare himself spiritually and her uncertainty about talking to him about God. She would worry about his spiritual soul getting to Heaven and would be bothered if he went to the other hospital and she hadn't discussed God with him.

By talking with the patient about God, K's stress would be relieved.

She would find this an effective way to deal with her stress and would feel good coping in that way.

Situation 2. This would be stressful for K, because she cannot answer the patient's question and due to the patient's discomfort. K would feel frustrated (at the lack of pain control and her inability to answer the patient's question) and helpless.

To deal with her own stress, K would: try to relieve the patient's pain (do things for the patient, request more medication); talk with other staff; and sit with the patient. K believes that no one should die alone and would feel good if she could sit with the patient.

She feels that the way she copes with her stress in this type of situation is the only way she can. "You have to accept the situation." K finds that she protects herself from a lot of stress at work by being close to only one patient at a time.

Situation 3. K would find this stressful, as she believes the upset patient is her first priority and would feel guilty and frustrated if she had to leave the patient.

To help her cope with her stress and with the situation, K would: try to get someone else to do her technical work if possible; take as much time as she could to talk with the patient and then do her other duties, telling the patient that she would be back; or get someone from support services to sit with the patient.

If she can't stay with the patient, she finds she doesn't cope as effectively with her stress. K finds these are the only ways for her to cope although they are not entirely satisfying.

Situation 4. This would definitely be stressful for K. She would feel anger (with the family, as she would be trying her best, and with herself for not getting through to the family) and self-doubt.

To cope with her stress, K would: try to understand the family's point of view; talk with other staff; talk with her husband; and not spend any extra time with that patient when the family was present.

It helps K to deal with her stress when she knows it is the situation that has upset the family and not her, but it bothers her that she gets angry.

Situation 5. K would find this situation stressful. She would feel angry, hurt (depending on the doctor who yelled at her) and guilty (if it was her fault).

Strategies that K might use to cope with her stress are: laughing at the situation (if it was a doctor who always yelled); talk to another staff member rather than confront the physician; and talk with her husband.

K finds getting her feelings "off my chest" helps her to feel better and is an effective way for her to cope.

What may be blocking the individual from coping better with job related stress? a.) at work: K believes that the hospital has services to help people cope with stress if they want to use them and that it is well staffed compared to other hospitals.

b.) in herself: K has difficulty turning to other people for help. She would not feel comfortable seeing one of the psychologists at work as she would be concerned about others knowing and would not want people to know if she wasn't handling things. She finds her pride and need for trust make it difficult for her to talk with others.

c.) in others: complaining.

What may help the individual to deal better with job related stress? a.) at work: nothing.

b.) in herself: K would like to be able to deal more directly with people in a stressful situation.

c.) in others: Stop complaining.

Coping resources. a.) social supports: husband, other nurses, friends.

b.) health/energy/morale: Her belief that everything will always work out helps her to keep a positive outlook.

c.) utilitarian resources: head nurse, doctors, support services, working part time (doesn't have to deal with the stress of working full time).

d.) general and specific beliefs: K has very strong religious beliefs that help her to cope with her stress. Her belief that everything will always work out is linked to her religious beliefs. Also, her philosophy about death and dying helps her to cope: "Everyone's going to die and we're all going to die in different ways and at different times and at different ages ... that's a known fact, so there's nothing you can do about it ... It's just something you have to accept."

e.) problem-solving skills: In situation 2, K used problem-solving skills to make the patient more comfortable, in turn relieving her own stress.

"Felt" effectiveness of coping strategies overall. K feels that she copes well most of the time and doesn't have much stress. The communication problem with the patient's family is a situation she is not sure how to handle; it may take her two or three days to work through the stress she would feel.

When K has coped effectively with her stress, she feels happy and more at ease.

Enough strategies for coping with stress? K feels that she could do more activities than she does to cope with stress.

Comments. K was interested in how she handled situations in comparison to others. She also wanted to know what would happen with the results.

Summary. K does not feel that she has much job related stress and, if she does have any, she tries to leave it at work. K's religious beliefs are very influential, giving her a positive outlook in dealing with stress and helping her to cope with death. One situation she has some difficulty in coping with her stress is communication problems with the patient's family.

Subject L

Works part time, has 1 - 5 years nursing experience and has been a ward nurse for 25+ months.

Coping strategies identified when dealing with stress generally. When L is feeling stress, she has the following indicators: her husband will notice a change; she is quieter; may stay up later at night; is more tired; is sad after the death of someone she has been involved with; has diarrhea; and feels muscle tension.

L described coping with stress as adequately handling stress so you are not functioning abnormally and are able to carry on with the functions of daily living. L uses many different strategies to cope with stress: working part time; believing in living for now; talking with her husband or a close neighbor; staying active with crafts, social activities, family and the community; and talking with other staff.

Situational examples.

Situation 1. L would find this situation stressful. She would feel guilty (over the patient's treatment), sad (because of his illness) and frustrated (due to the lack of time and not knowing if she was really helping him).

To cope with her stress, L might: remove herself from the situation; assess the patient's needs and do as much for him as she can; and talk with her husband.

These are effective ways for L to cope with her stress.

Situation 2. L would find this stressful. She would feel frustrated (at not being able to do more for the patient).

To cope with her stress, L would pray for the patient and do as much for her as she could.

These would help L cope effectively with her stress.

Situation 3. This situation would not be stressful for L. She feels she has learned to cope well with all of the activity and has organized herself in her mind how to deal with her assignments.

Situation 4. L would not find this situation particularly stressful. She would not feel it was her fault that she could not get the catheter inserted and she would view the son's statement as a comment on his own stress. She has never had a situation like this happen.

Situation 5. L has not had this situation happen and was uncertain of how stressful it would be for her. She thought that it would likely upset her.

To deal with any stressful feelings that might arise, L might attribute the problem to the doctor; review her past actions; and cry.

L felt these strategies would deal with her initial stress, but she would have trouble working with that doctor in the future.

What may be blocking the individual from coping better with job related stress? a.) at work: Not being able to refer patients and families directly to the psychologists.

b.) in herself: nothing.

c.) in other: if the other staff is incompetent or if there are not enough physical resources in the environment.

What may help the individual to deal better with job related stress? a.) at work: nothing.

b.) in herself: Gaining experience as she grows older and improving her skills in working with families of dying patients.

c.) in others: nothing.

Coping resources. a.) social supports: husband, close neighbor, other staff, patients.

b.) health/energy/morale: Keeping busy and active at home and in the community.

c.) utilitarian resources: psychologists, working part time.

d.) general and specific beliefs: Her religious beliefs are very important to L, giving her a sense of continuity after death. Also, she believes in living for now, appreciating the fragility of life.

e.) problem-solving skills: L illustrated the use of problem-solving skills in situation 3, where she discussed how she organized herself to cope with a busy work day, so that it wasn't stressful.

"Felt" effectiveness of coping strategies overall. L feels her overall effectiveness is good. She does not find work that stressful. L knows she has coped effectively with her stress when she feels good, has energy and enthusiasm and is happy again.

Enough strategies for coping with stress? L feels she has enough strategies for coping with stress.

Comments. L quite enjoys her job. She was interested in the results of the study.

Summary. L felt she coped well with her job related stress and did not find her work that stressful. Working part time was an important coping strategy for L; she felt there was more stress for full time staff due to their exposure to chemotherapy and "hot" patients. L stated that she felt the stress increased the longer the nurse worked at the Cross, but that they got more used to coping with it. L's positive perspective, her belief in living for now and her religious beliefs help her to cope with the stress she encounters.

Subject M

Works part time, has 5+ years nursing experience and has been a ward nurse for 3 - 12 months.

Coping strategies identified when dealing with stress generally. When M is feeling stressed, she has the following indicators: fatigue and a need to sleep more; attitude changes (less "bubbly", reacts negatively and is more irritable); neck strain and headaches; tendency to tearfulness; and reduced appetite.

M described coping with stress as returning her body to a peaceful state. M uses the following coping strategies: talking to her husband and co-workers; exercising; practicing yoga and meditation; carrying on with normal daily activities; reading; doing crafts; and going out socially.

Situational examples.

Situation 1. This would be very stressful for M; she could relate the situation to one in her experience. She would feel sadness (due to the quickness of the illness), frustration, and some fear (of herself not dying peacefully and not having her own life in order).

To cope with her stress, M would: consider her now resolved spiritual beliefs regarding death; do as much for the patient as she could; think about the situation for a few days and perhaps cry; and do normal daily activities.

She feels she copes fairly effectively with this type of stress, but finds that her coping depends upon the patient and the family.

Situation 2. M would find this situation stressful. She would feel frustrated (due to the patient's pain and suffering) and sad.

To deal with her stress, M would: tell the patient that God will choose her time; talk with her co-workers; may cry with the patient and the family; try to go on with her other work; and if really stressful, get someone else to care for the patient.

M feels that she has grown accustomed to this type of situation as it happens often, but she finds she doesn't always cope with her stress effectively when someone she is close to is suffering. If she gets someone else to care for the patient, she feels good that she has been perceptive of her own stressors and acknowledged her own limitations.

Situation 3. For M, this would be a stressful situation. She would feel frustrated (that she can't give the emotional support the patient needs).

To cope with her stress, M feels there are many resources she can draw upon: get a volunteer, psychologist or family member to sit with the patient. Also, she may get some help with her physical work.

M has not really resolved how she deals with this situation; she finds that it only bothers her sometimes. She feels she copes as best she can with the situation. She also finds it helps her to cope if she vocalizes her concerns.

Situation 4. M would find this stressful and very hard to deal with. She would feel frustrated (when the family are not coping well with their fe[illegible] and angry.

M [illegible] that sometimes she does not deal with her stress in this situation. She may try to put the family's reaction in context with the situation and try to understand their feelings. She may also confront them.

M is not totally satisfied with how she copes with her anger in this situation, especially if she becomes angry and flippant with the family.

Situation 5. This is a stressful situation for M due to what she described as the hierarchy in the medical system. She would feel hurt, intimidated and angry.

To cope with her stress, she might talk with the head nurse. M feels that nurses are sometimes the brunt of frustration of doctors, patients and families and feels this is why nurses sometimes do not cope well with stress.

In a similar situation, M found that her feelings stayed with her, that she was angry and hostile for a time, and avoided dealing with that doctor. She does not feel that her coping in this situation is effective.

What may be blocking this individual from coping better with job related stress? a.) at work: Not enough staff, leading to stress from fatigue and too much responsibility.

b.) in herself: Getting frustrated and angry and then not coping with a situation; also prejudging a situation and jumping to conclusions.

c.) in others: Doctors not emphasizing the psychological care of the patients, which M feels is important.

What may help the individual to deal better with job related stress? a.) at work: M finds the educational facilities at the hospital to be excellent, but feels there is a need for more seminars and more staff when seminars are offered so that it is easier for staff who are working to attend.

b.) in herself: Maintaining a high level of motivation to attend workshops/classes.

c.) in others: nothing.

Coping resources. a.) social supports: husband, other staff, friends.

b.) health/energy/morale: exercise, yoga, meditation, tries to eat a balanced diet and get enough sleep.

c.) utilitarian resources: psychologists, educational facilities at the hospital, head nurse, working part time.

d.) general and specific beliefs: M has a belief in her professional competence that helps her to cope with her job related stress. Her spiritual beliefs regarding death also help.

e.) problem-solving skills: This resource was not really illustrated by M.

"Felt" effectiveness of coping strategies overall. M feels she copes well with her stress. She knows she has coped effectively when she feels calm and good after a day's work.

Enough strategies for coping with stress? M believes she has enough strategies for coping with stress but would like to know more since she encounters new stresses, new situations and new people everyday.

Comments. M found the interview covered the area of coping and that the questions were to the point.

Summary. M identified areas where coping strategies were not very effective, however, she felt she coped well with her stress overall. Situations, where the communication with the family or doctor was difficult and where there were time demands, were the ones where she was uncertain of her coping effectiveness. Working part time helped M to cope with her stress. M felt fulfilled by her job and well suited to what she described as very warm, physical nursing where she could deal with her patients on a personal basis.

Subject N

Works part time, has 5+ years of nursing experience and has been a ward nurse for 13 - 24 months.

Coping strategies identified when dealing with stress generally. N has the following stress indicators: fatigue; physical symptoms (joints and back hurt); change in her sleeping pattern (either not getting enough sleep or sleeping more than usual); a pessimistic attitude about everything; and taking her feelings out on her husband.

Coping with stress for N means taking time for herself, finding the source of stress and working on it. When asked about her coping strategies, N felt that she let her stress go too long; she may feel angry and isolate herself by sleeping and ignoring the stress until it builds up. Then she tries to determine what is bothering her and confront it.

Situational examples.

Situation 1. This would be stressful for N due to the patient's lack of time to prepare himself spiritually and the way he died. She would feel frustrated (that we all can't be prepared spiritually for death, reflecting upon her own ignoring of this preparation for herself) and resentment (that he died at another hospital and she wouldn't have been with him).

To cope with her stress, N might: cry; pray; talk aloud to herself on her way home to try and understand her feelings. N finds that she releases most of her tension on the way home. She is also involved with photography and uses this to distract herself and appreciate the life around her.

N finds these strategies effective and feels good coping in these ways. She also talks with other staff and knowing that they feel the same way helps. N stated that it was unfortunate the nurses did not talk more to the psychologists and individuals or groups, as she feels this would help them to cope with their stress.

Situation 2. This would be a stressful situation for N. She would feel angry (that the patient wasn't dying peacefully).

To cope with her own stress, N would try to do something for the patient to make her more comfortable and would talk with the other nurses.

The effectiveness of these strategies depends on what happened with the patient; if something positive happens, N feels better. If nothing happens, N may still feel angry and redirect her feelings at home. N does not feel she deals well with this type of stress.

Situation 3. N would find this stressful. She would feel frustrated (due to the number of demands placed upon her) and inadequate (wondering about her own organizational skills).

To cope with her stress, N might: ask for help with the technical demands; "brew inside" until she can talk with other staff and perhaps "blow her stack" with them; and be honest with the patient about her work demands.

Being able to vent her feelings would help N feel better. She feels she copes well with this type of stress.

Situation 4. N has encountered coldness from patients' families before, but has never been told she was incompetent. She would not find their attitude particularly stressful, would attribute it to the situation, and focus her attention on the patient.

Situation 5. N would find this situation stressful and would feel angry with the doctor.

To deal with her stress, N would likely verbalize her feelings with the other staff and her husband.

N finds it helpful to cope with her stress when she talks with other staff as they understand what she is going through.

What may be blocking the individual from coping better with job related stress? a.) at work: No longer being able to refer the patients directly to the psychologists. Also, N would not feel comfortable stopping in to talk with a psychologist as she has been told they are too busy.

b.) in herself: N is very critical of herself and feels that she needs to be more aware of her own limitations.

c.) in others: lack of communication from the doctors.

What may help the individual to cope better with job related stress? a.) at work: N feels it is important to have an ongoing counselling service for the staff, as she doesn't feel the staff are able to talk with the psychologists who are available or would have to go through their head nurse to get an appointment.

She would like to have more frequent meetings on the wards, so that they could "clear the air" and "get things off their chests." Also, N finds it harder to cope with stress toward the end of four - twelve hour days and feels more staff would help. She would also like to be able to rotate through the other departments to get a better understanding of their operation.

b.) in herself: To help herself cope with stress, N feels she needs to increase her outside activities, so that she spends less time thinking about patients on her days off. She would also like to keep open communication with her husband and friends so she can discuss things that are bothering her.

c.) in others: N would like more honest, open feedback and communication. She would like the psychologists to meet with the nurses to discuss stress and burnout and also to inform them about how certain families are coping. N found the first six months she worked at the hospital to be extremely stressful, particularly due to the numerous deaths, and would have liked a workshop on dealing with death.

Coping resources. a.) social supports: husband, other staff and good girlfriends.

b.) health/energy/morale: N uses photography to boost her spirits. She finds it harder to cope with stress when she is tired.

c.) utilitarian resources: Psychologists were frequently mentioned as a resource she would like to use more.

d.) general and specific beliefs: N's faith helps her to cope and sometimes gives her an "easy reason" for what is happening when someone is dying.

e.) problem-solving skills: N uses problem-solving skills when she tries to determine what is stressing her.

"Felt" effectiveness of coping strategies overall. N believes that she copes effectively overall. She knows she has coped effectively when she feels happier, more communicative and energetic.

Enough strategies for coping with stress? N finds that she has enough strategies and can help herself to cope with any type of stress.

Comments. N thought that all the situational examples were stressful but in different ways. She felt the situations were good, but found it hard to say how she would handle her stress. She was interested in the results.

Summary. N felt she coped effectively overall with her stress, but expressed a need to talk more and share with others her feelings about death, dying and other issues at the hospital. One situation N did not feel she dealt with her stress well was where her patient was suffering. Being able to vent her feelings helped N cope as did working part time, but she would like to find more to do with her time off.

Subject O

Works part time, has 5+ years nursing experience and has been a ward nurse for 25+ months.

Coping strategies identified when dealing with stress generally. When O is feeling stressed, she has the following indicators: irritability (more short tempered than usual) and feelings of being under pressure. When O is tired, she feels stress more easily.

For O, coping with stress is finding outlets for the stress and feeling comfortable dealing with stress. Working part time is a coping mechanism for O; she feels that it has helped her to stay at the hospital for as long as she has. Other strategies O uses are: talking with other staff; keeping her home life separate from work; being involved in athletics and with her children and their activities; getting help and support from her husband; not dwelling on things that happen at work; and changing her assignment. O feels that her nursing experience has also helped her to cope with her stress at the hospital.

Situational examples.

Situation 1. This situation would be very stressful for O as it is hard for her to accept the death of a young person. O would feel intense sadness, frustration and anger at the death of someone so young.

To cope with her stress, O might: cry; feel lucky about her own health and that of her family; do all she can for the patient and family while being aware and accepting of her limitations; and talk with other staff.

O feels she copes effectively with stress in this type of situation.

Situation 2. O would find this upsetting due to the patient's pain, but would not define it as stressful since the patient wants to die.

Situation 3. This situation would be stressful for O, especially if the distraught patient (being from up north) did not speak English. O would feel frustration due to the time pressures and any possible communication problems.

To cope with her stress, O would: get help from someone in support services to be with the patient; this helps to take the pressure off: "if you can't cope with it, there's usually someone who can help."

Getting someone else to be with the patient is an effective way for O to cope with the stress in this situation.

Situation 4. O would find this situation stressful since families can be hard to deal with at times. O would be angry (especially if she was tired).

To cope with her feelings, O might: "stomp around for half an hour before I go back in"; talk to herself about the family's feelings and try to accept them; go back and talk with the family or get someone else to talk with them.

O felt that her coping strategies for this type of situation seemed effective.

Situation 5. This situation is not usually stressful for O. Working part time, she is likely not to know what the doctor is referring to and would pass his concerns onto her head nurse.

What may be blocking the individual from coping better with job related stress? a.) at work: nothing; O feels the hospital is set up to help the staff and is open to suggestions.

b.) in herself: Getting too tired.

c.) in others: nothing.

What may help the individual to deal better with job related stress? a.) at work: nothing.

b.) in herself: Get more rest and try to work more day shifts. O stated that if she were working full time at the hospital, she would be actively seeking diversions outside the hospital to cope with the stress. For O, work is a part of her life and is balanced by her home life.

c.) in others: Getting more information on the disease process from others, so that she can understand more.

Coping resources. a.) social supports: husband, friends, other staff, patients ("they give a lot and are always grateful.")

b.) health/energy/morale: O realizes how important it is for her to be well rested so she can cope effectively with stress. She is also actively involved in athletics.

c.) utilitarian resources: working part time, support services.

d.) general and specific beliefs: O believes that in some situations there is nothing she can do to stop or change what is happening and accepts her limitations.

e.) problem-solving skills: This resource was not specifically illustrated.

"Felt" effectiveness of coping strategies overall. O feels she copes quite well, but fatigue is her worst enemy when trying to cope with stress. She does not feel that her work causes her any more stress than her home life. O knows she has coped effectively with stress when she feels she has done a good job and does not feel frustrated nor overloaded.

Enough strategies for coping with stress? O believes that she has enough strategies for coping with stress and that it is not often that she does not have something to do.

Comments. O found the interview interesting and good. She found the hospital a nice place to work as it was satisfying nursing and she was learning a lot about people, grief and living.

Summary. O found that she coped well with her job related stress. She felt this was due to her nursing experience and keeping a balance between work and home life; O was also aware of and accepting of her limitations. Her peak stress occurred when there were many terminal patients on the ward. Also, fatigue could prevent O from coping well with stress.

Coping strategies used

Table 3 illustrates the use of the coping strategies presented to the respondents in the interview. They responded as to whether they used a strategy frequently, sometimes or not at all. The letters in the table represent the specific subjects and their responses. Abbreviated versions of the strategies are used in the table.

TABLE 3

Use of coping strategies

	USE		
STRATEGY	Frequently	Sometimes	Not at all
1 Seek more information	A,B,C,D,E,G,L,M,N	F,H,J,K,O	
2 Talk with friends/relatives	A,C,D,F,H,J,K,N	B,E,G,L,M,O	
3 Talk with other professionals	A,B,C,D,E,F,G,H,J,K,L,M,N,O		
4 Don't worry about it	G,K	A,B,C,E,F,J,L,O	D,H,M,N
5 Do something else to take mind off it	A,C,D,E,G,H,K,M,N	B,F,J,O	L
6 Try to reduce tension	B,C,D,E,F,G,K,L,M,N	A,H,J,O	
7 Develop different ways to deal with it	A,G,L,N	C,D,E,J,K,M,O	B,F,H
8 Prepare self to expect worst	H,K,L,N	C,D,F,J,M	A,B,E,G,O
9 Take positive concerted action	A,B,C,D,E,G,H,J,K,M,O	F,L,N	
10 Recall past experiences	C,G,J,L,M,N	A,B,D,E,K,O	F,H
11 Rework situation in your imagination	A,D,G,H,L,N,O	C,E,F,J,K,M	B
12 Keep your perspective	A,C,D,E,F,G,H,K,L,M,O	B,J,N	
13 Philosophical and spiritual meaning	A,F,G,K,L,M,N	C,E,H,J	B,D,O
14 Remain cool and objective	D,E,F,G,K,M	A,B,C,H,J,L,N,O	

CHAPTER V

DISCUSSION AND CONCLUSIONS

Overview

The purpose of this exploratory study was to investigate how nurses cope with stress encountered in an oncology setting. More specifically,

1. What coping strategies are used?
2. What coping resources are used?
3. How effective do the nurses consider their coping strategies to be?
4. What blocks a nurse from coping better with job related stress? What do they feel would help them to cope better?
5. What differences, if any, are due to the demographic variables of: working full time vs. working part time; length of time as a nurse; and length of experience as a ward nurse in an oncology setting?

By identifying these factors, it was hoped that this study would: lay groundwork for research more empirical in nature; and help the population from which the nurses were drawn in coping with their job related stress.

Participants were selected from ward nurses at one hospital (Cross Cancer Institute, Edmonton) that specializes in the treatment of cancer. An interview format was developed by the investigator to answer the above questions. The results were descriptive as opposed to statistical and, due to the exploratory nature of the study, may be somewhat restricted in their application.

Discussion

The research questions outlined previously will be discussed in that order. There will also be a discussion of the respondents' perceptions of coping as a possible influence on their coping process.

What coping strategies are used?

The specific strategies discussed by Sidle et al (1969) and Jacobson (1976) were used as guidelines for the coping strategies presented to the subjects during the interview and to categorize the coping strategies in the situational examples. The strategies will be discussed in terms of most used to least used as well as in relationship to the three types of coping strategy identified by Pearlin and Schooler (1978). The classification system for coping strategies proposed by Lazarus and Launier (1978) will be applied to one coping strategy to illustrate the system's use.

Coping strategies. a.) Talking with other professionals about the situation (strategy 3) was the only strategy all the respondents stated they used frequently. Talking, particularly to other nurses, was a major coping strategy. Other nurses were a source of moral and emotional support, information, feedback and physical help. The psychologists on staff were also seen as someone to talk to, however, three concerns related to using them were expressed: not having the opportunity to talk with them (due to time constraints by the nurses and the psychologists, a lack of structured contact); that any contact on an individual basis would be known by others; and that the psychologists were too busy. Doctors, head nurses and supervisors received mention as other professionals the nurses talked with when coping with stress. The importance of this verbal contact with others in coping with stress is supported in the literature. Vachon (1978) discussed the importance of the team approach and the need for support inside and outside of work in helping nurses in a palliative care setting cope with stress. Patrick (1981), Gray-Toft (1980) and Sonstegaard et al (1976) also emphasize the importance of and need for support.

Pearlin and Schooler (1978) identified three types of coping strategy: 1.) responses that change the situation, aimed at changing or eliminating the source of stress; 2.) responses that attempt to control the meaning of the stressor after it occurs, but before the emergence of stress; and 3.) strategies that manage the stress, minimizing the the individual's discomfort, while doing nothing about the source of stress. The effectiveness of talking to other professionals could be related to the possibility that it can be used to achieve any of the three types: to change the situation (talking to others to reduce the heavy workload in Situation 3); controlling the meaning of the stressor after it occurs, but before the emergence of stress (talking with colleagues, minimizing the impact of an incident); or to just manage the stress ("blowing off steam" with other nurses when angry with a patient's family).

b.) The following strategies were used either frequently or sometimes by all of the respondents.

Many of the nurses found talking to their spouse (if married), to good friends or to family (strategy 2) helped them to cope with their stressful feelings. The need to be listened to and supported was emphasized. In Pearlin and Schooler's (1978) scheme, this strategy deals with the management of the individual's stress and is sometimes used where changing the source of stress was not possible (as in the death of a patient).

Trying to reduce the tension (strategy 6) was done in many ways: sleeping, exercising, smoking, drinking, eating, using humor, meditating, practising yoga, etc. Some of these strategies for reducing tensions (exercising, using humor, meditating) can be considered healthier than others (drinking, smoking, eating). Subject D expressed concern over her use of alcohol to cope with her stress in a particular situation, a concern voiced by one of the subjects in the pilot study. Trying to reduce tension is used to minimize the individual's discomfort, while not affecting the source of stress (Pearlin and Schooler, 1978).

Taking a positive concerted action based on present understanding of the situation (strategy 9) seemed to be an important strategy for the nurses to use, particularly in situations involving patient care. If the patient could be helped (their problem being the source of stress), then the stress was more easily resolved. This may relate to Lefcourt's (1974) idea regarding the amount of control an individual feels he has over the stressor: the degree of felt control is inversely related to how stressful the situation is perceived to be. Pearlin and Schooler (1978) would describe this strategy as one that changes or eliminates the source of stress.

Looking for ways to keep perspective (strategy 12) was a helpful strategy and was well illustrated by Subject K and her belief about death and dying ("Everyone's going to die in different ways and at different times and at different ages ... that's a known fact, so there's nothing you can do about it ... it's just something you have to accept); her belief helped her keep her perspective when a patient died. This cognitive coping strategy can be used to control the meaning of the stressor after it occurs, but before the emergence of stress, or can manage one's stress after it emerges.

Remaining cool and objective (strategy 14) was a strategy illustrated by Subject E in Situation 1, where she spoke of putting a "shell" around her feelings, and by Subject J in Situation 2, where she might use this approach with a dying patient with whom she was not familiar. This strategy can be used to control the meaning of the stressor (the individual cognitively removes herself from the situation, thereby making it less threatening) or as a way of managing the stress (controlling of feelings). Caution is needed when using this strategy for several reasons: it may interfere with a nurse giving emotional support to a patient; it could interfere with a nurse receiving support from colleagues and family; and it could encourage cumulative stress. However, it is a necessary skill in some direct care situations and may be valuable in protecting a nurse from exposure to too much stress at a given moment.

c.) The following strategies were used by thirteen of the fourteen respondents (however, they were not the same thirteen for all the strategies).

Seeking more information (strategy 1) was done in many ways: reading, attending more workshops and inservices, and talking with others. This strategy can fit into any one of the three types described by Pearlin and Schooler (1978): e.g. reading about a procedure may reduce one's anxiety about it, eliminating the source of stress; information can be used selectively to make a stressor less threatening; or attending a workshop may help to manage the stress, while doing nothing about the source.

Doing something else to take your mind off what has happened (strategy 5) was often done by focusing on other duties. Another facet of this strategy, mentioned by several of the respondents, was keeping work and home separate. Vachon (1978) discussed a healthy balance between work and outside life as a way to improve one's coping with stress. Pearlin and Schooler (1978) would describe this type of strategy as one that attempts to control the meaning of the stressor (by making one area of one's life more important than the one where the stress originates).

Many of the respondents found that they frequently reworked situations in their mind (strategy 11) to affirm what they did, though Subject B found that this could work against her at times, as a situation could get blown out of proportion. This is illustrative of Pearlin and Schooler's (1978) second and third types of coping strategy: the stressor can be made cognitively less threatening, thereby controlling the meaning of the stressor after it occurs but before the emergence of stress; and can also minimize the individual's discomfort.

d.) Twelve of the fourteen respondents used recalling past experiences to see how they dealt with similar situations (strategy 10). Subject G found this strategy particularly helpful in Situation 4; thinking about how she dealt with other difficult families, as well as about positive experiences, would help her to cope with her stress. This strategy would be used as a response to control the meaning of the stressor, as well as to manage the stress (Pearlin and Schooler, 1978).

e.) For eleven of the fourteen respondents, searching for philosophical and spiritual meaning to their experiences (strategy 13) was important. Many of the nurses found their religious and philosophical beliefs very helpful, particularly when coping with stress related to death and dying. This strategy could also be used to control the meaning of the stressor and to manage the individual's stress.

f.) The following two strategies were used by ten of the fourteen respondents.

- Don't worry about it; what's done is done (strategy 4) can be used to control the meaning of the stressor as well as help to minimize the individual's discomfort. Those who did not use this strategy tended to worry about a situation and needed other input to cope with the stress.

Developing different ways to cope with a situation (rather than relying on the same strategies in all similar situations) (strategy 7) would likely be aimed at changing or eliminating the source of stress. One nurse who did not use this strategy stated she relied upon the same strategies in different situations. However, research has shown that the more strategies and resources an individual has, the more effectively he/she is likely to cope (Sidle et al, 1969).

g.) Nine of the fourteen respondents used preparing themselves to expect the worst (strategy 8) as a coping strategy; this was the least used strategy (though over half the nurses used it). It might have been better worded as just "Prepare yourself for the situation"; "worst" may have given it a negative connotation to this strategy. For example, Subject E felt she would cope better with her stress if she came to work a little earlier to look over her assignments for the day; this is a type of preparation, but it is certainly not for the worst. By changing the wording of this strategy, it would encompass both types of preparation. This strategy could fit into either of these types: make a stressor less threatening or manage the emotional stress of the individual.

All of the coping strategies were well used, supporting the importance of each in coping with stress. Pearlin and Schooler's (1978) types of coping strategy illustrated that goals and means are not synonymous; basically three ends can be achieved through numerous means.

Classification of coping strategies. Lazarus and Launier's (1978) system of classifying coping strategies can be applied to the strategies used by the nurses. However, where a strategy fits in the model depends upon its temporal orientation, focus, function and coping mode. This can be illustrated by using the strategy of talking with other professionals about a situation. This strategy can be: past-present (talking with other staff about an angry family a nurse is working with) or future (talking over concerns related to the impending death of a patient); self focused (whether the nurse can do something different with an angry family) or environmentally focused (talking about hospital policy); instrumental in function (talking to a doctor who is confronting her) or palliative ("blowing off steam" about the doctor with other nurses); and of the information seeking mode (finding out how to talk to a family whose loved one is dying), direct action mode (asking for a change in work assignment), inhibition of action mode (talking with other nurses when angry with a physician) or intrapsychic mode (talking about something unrelated to the patient who just died). By being able to classify a strategy, it then may be possible to generate other strategy options for coping using the same basic strategy, but in a different way.

Summary. One of the aims of this study was to remain open to finding new strategies that were not encompassed by the list of strategies used in the interviews. The strategies discussed in the open ended part of the interview werefound to fit in with the fourteen strategies already identified. However, as mentioned earlier, a change in the wording of strategy 8 may help it to encompass more coping behaviors.

The nurses found it difficult to answer how they coped with their stress, because their responses to stress in many situations seemed to be automatic and they really had to think about what they did. The automatic nature of some of their responses may place them under the larger umbrella of adaptation (discussed in Chapter II) rather than the more specific realm of coping (where responses are less clear and less guaranteed in their adequacy). Also, the difficulty in pinpointing their responses may also have been due to coping with stress as being something to which they had given little previous thought. Some of the respondents found the interview helped them to clarify for themselves how they did cope. Many of the responses seemed situationally focused (coping with the environment) rather than specifically focused on dealing with the individual's stress; however, since their stress is linked to the situation, it was often relieved by a change in the situation.

Unconscious coping mechanisms (defense mechanisms), which are an important part of the coping process, were not measurable due to the nature of the research (interview); these types of strategies likely make an important contribution to how the nurses cope with stress and might be more easily ascertained through observation and personality testing.

The coping strategies used by the nurses support those outlined in the literature (Sidle et al, 1969; Jacobson, 1976). Three types of coping strategy identified by Pearlin and Schooler (1978) were also supported and an example of classifying strategies using Lazarus and Launier's (1978) model was given.

What coping resources are used?

Folkman et al (1979) identified five resources used in coping (as described in Chapter II). These five resources were used as a guide to determine what resources were used by the nurses to cope with stress. All of the coping resources outlined by Folkman et al (1979) were used by the respondents, though not all the respondents illustrated a use of all of the resources. If the use of a resource was not illustrated by an individual, it likely meant: 1.) the person does not use that resource; or 2.) the use of that resource was not elicited by the interview. How each resource was utilized and its importance shall be discussed. Also, the implications of the lack of use of a resource and the possibility of a sixth resource shall be put forward.

Social supports were used by all of the respondents as a coping resource. Here again the importance of support from co-workers was emphasized. The need to discuss feelings and situations and receive emotional and moral support from other nurses was repeated several times. This need is supported in the literature dealing with the stress issues of nurses (Vachon, 1978; Gray-Toft, 1980; Patrick, 1981; Sonstegaard et al, 1976).

Health/energy/morale as a coping resource was not used by all the respondents. However, the importance of activity, exercise, rest, positive attitudes and awareness of self and own limitations was emphasized by several of the respondents as key factors in helping them cope with stress.

Utilitarian resources are those coping resources available within the environment. Working part time was a major coping strategy for the part time staff and is part of the utilitarian resources. Full time staff were helped by having several days off between shifts. Support services (especially the psychologists), workshops and inservices were seen as important, but, to some extent, underutilized. Many of the respondents requested more involvement with the psychologists on an individual or group basis and more workshops in the areas of stress and coping, death and dying, and working with the family of the dying patient. Also, more staff for the wards when workshops were offered was mentioned so other staff could attend without overloading the staff that remained on the ward. The pastor, volunteer services, supervisors, head nurses, interns, and doctors were also identified as utilitarian resources.

General and specific beliefs helped many of the respondents to cope with stress. For several of them, their religious beliefs helped them to cope, particularly with stress related to death and dying. Beliefs in personal competence, skills and abilities, generally positive attitudes and an acceptance of the way life can be were also important for coping with stress. This resource likely has a great deal of impact on cognitive appraisal involved in coping. It would affect how the individual assesses the impact of an event on his/her well being (primary appraisal) as well as what the individual uses to cope (secondary appraisal).

Problem-solving skills were illustrated by the responses the subjects made in specific situations. They would often try many different ideas when helping a patient and, by helping the patient, they would relieve their own stress.

The subjects had some difficulty naming specific resources they used and so, for many subjects, their use of a resource was extrapolated from the strategies they described. Also, for the subjects where a specific resource was not apparent, it was difficult to know if they had a satisfactory alternate resource or if the resource was being underutilized. If the resource was being underutilized, it may be one the individual needs to be made more aware of, to enhance his/her coping effectiveness.

A possible additional resource may have been uncovered. Subject G referred to herself as a coping resource: "Knowing where your failings are, what causes stress within and what makes it go away." This response was placed in the resource category of "Health/energy/morale", but self awareness may be a potential coping resource. Vachon (1978) discussed the importance of personal insight in helping nurses to understand and accept their own limitations so that they can cope better with stress. Self awareness also relates to Pearlin and Schooler's (1978) psychological resources (personality traits individuals use when dealing with threats from the environment). The importance of self awareness is touched upon in the resource categories of "Health/energy/morale" and "Beliefs," but it may have more influence than allowed by Folkman et al (1979). Since components of self awareness have been identified (Jevne, 1978) (and include: personal beliefs, values, attitudes, professional and personal competencies and incompetencies; personal needs/wants/aspirations; impact of one's own personality on others; emotional reactions; personal limitations; and developmental history), investigation is needed to determine whether or not self awareness can be considered another coping resource.

All of the resources outlined by Folkman et al (1979) were used by the respondents, but their use by specific individuals seemed to depend upon the individual (lending support to the concept of coping as a transaction). Lack of indicated use of a resource may be signs of a resource being underutilized and point to a need for more awareness of available resources and how they can be tapped. The resource of self awareness should be considered as a possible addition to Folkman et al's (1979) list, but more support for it as a resource is needed.

How effective do the nurses consider their coping strategies to be?

The term "felt" effectiveness was used, as there may be a difference between "felt" effectiveness and the actual effectiveness of a strategy used to cope with stress. "Felt" effectiveness was the only type measurable in this study. All of the nurses interviewed felt they generally coped effectively, although some of them found circumstances where this was not the case.

Overall coping effectiveness. Though the overall coping effectiveness was described as good by all of the respondents, some of the nurses found a lack of "felt" effectiveness in certain circumstances. The lack of effectiveness in coping with stress was apparent to them due to the continued presence of stress indicators and was related to many different factors: presence of dreams and feelings of impending danger (Subject B); feelings of helplessness (Subject C); the longer the time in the work setting, the less able she felt to cope (Subject F); "falling apart" at home due to work stress (Subject H); unexpected stressful situations (Subject J); communication problems with the patient or family (Subject K); and physical factors (Subject O).

This helps to illustrate that, although overall effectiveness in coping with stress can be felt to be good, there can be areas where one has difficulty coping or that are affected by how one copes with stress. Awareness of such areas is important; a lack of awareness can lead to burnout.

Effectiveness with situational examples. The situational examples were to represent five different areas of stress a nurse in an oncology setting might encounter (Arcand, 1980). Coping effectiveness in the situational examples varied among the individuals, with many similar and different strategies emerging, as well as a lack of coping effectiveness for some individuals in some situations. It is important to note here that some of the situations for some of the respondents were not stressful; this seemed to be due to factors such as: beliefs (philosophical and religious), amount of nursing experience, personality traits, expectations and life experiences. Rather than discuss each specific situation and the strategies used that seemed to be effective, strategies that seemed effective generally will be discussed in relationship to the specific situations. Results from the specific situations appear to have simply confirmed other interview data.

Talking with others, especially other nurses, emerged as a common and effective coping strategy in all of the situations. Being able to share feelings, verify procedure and get moral and emotional support were very helpful for the nurses when dealing with stress. The importance of and need for this kind of support was discussed earlier.

Working part time was another effective coping strategy. By balancing their work with their outside life, having long breaks between work days, having less patient contact and having less administrative and "political" involvement were helpful for the part time staff.

Beliefs were important coping strategies. Religious, philosophical and personal beliefs varied among individuals, but were often helpful when coping with stress related to death or suffering and dying. Beliefs in oneself were particularly effective when dealing with a situation that tested the individual's skills and abilities.

Being able to do something for a patient or the patient's family and the effectiveness of those actions on the patient's or the family's distress influenced the "felt" effectiveness and the success of those actions as coping strategies. This is particularly apparent in the responses to Situations 2 and 3. If the patient or family had not been helped, then for some of the nurses (six of the fourteen), the "felt" effectiveness of their coping strategies was not as great.

As Subject M stated: "If it [a coping strategy] was not effective, I wouldn't use it." This seems to apply to the rest of the respondents. Strategy effectiveness depends upon the individual, their interpretation of the situation, state of mind, expectations, etc. Often numerous strategies are used in one situation (the advantage of having a repertoire of coping behaviors is discussed by Sidle et al (1969)). Also, the individual may use a strategy that worked before or try a new one. It was sometimes difficult for an individual to think of how she would cope with a situation and how effective some strategies might be. This might be more easily determined by comparing the interviews with observed behaviors or by discussing with the individual (after the occurrence of a stressful event) their strategies and consequent effectiveness. If awareness of coping strategies and coping effectiveness is a positive influence, then the nurses might be helped to become more effective copers by gaining this awareness. They may be able to concentrate more on using those strategies that seem more effective and eliminating those strategies that seem less effective or those strategies that seem effective but are unhealthy.

What may be blocking the individual from coping effectively with job related stress?

Three variables were considered in this category: work, self and others. The nurses were asked to identify those things in each category which may be blocking them from coping better with stress.

In the area of work, six of the fourteen nurses found nothing that blocked them from coping with stress. Seven of the fourteen nurses spoke of the availability of good support systems and help (emotional and physical) at work when asked this question. Three of the respondents felt the hospital was short staffed, contributing to their stress. Other blocks were: the busy nature of the hospital, not allowing one to attend to her stress; lack of continuity of patient assignment; lack of feedback; lack of extra staff when inservices/workshops are offered; and not feeling comfortable seeing the psychologists (told they were too busy). These blocks seemed to add to the nurses' stress rather than necessarily prevent them from using certain strategies to cope.

Those factors that may be blocking the nurses from coping have some commonalities, but are also individual in nature. This is well illustrated by those blocks found within the self. One nurse could think of nothing within herself that blocked her from coping better with her stress. Avoidance of confronting a stressor, short temperedness and ignoring of own feelings were blocks reported by two of the respondents (a different two in each case). Other blocking factors within the self that were expressed by individual respondents were: dwelling too much on a situation; avoiding a situation where there was death or dying; not taking time to cope with own stress; not getting enough sleep; getting overinvolved emotionally with patients; having difficulty turning to others for help; and being self critical.

For the category of others, four nurses could think of nothing that others were doing to block them from coping more effectively with job related stress. Three nurses found that others who would not listen or be supportive blocked them. Additional blocks by others were: if they were uncaring, uncooperative or impatient; if there were many new staff to be taught; lack of feedback from other staff; complaining; incompetence; lack of emphasis on the psychological care of the patients; and a lack of communication with the doctors.

As was stated earlier, that which blocks the individual from coping with job related stress has commonalities, but tends to be individual in nature. This points to the need for awareness in individuals of what may be blocking them from coping, so that they may be able to institute possitible change to help themselves.

What may help the individual to cope more effectively with job related stress?

The areas of work, self and others were again explored. What helps a person to cope more effectively also has similarities and individual differences.

In the area of work, five of the respondents felt that the hospital could add nothing else to help them cope more effectively with stress; the support and educational facilities available were described as very good and helpful. Many of the other subjects expressed this as well, but commented on some things they felt would help: more stress management workshops; more meetings with staff to share feelings; more contact with the psychologists; more staff; time and place to study charts; a nurses' lounge; fitness programs made available at different times; rotation through other departments; and less exposure to chemotherapy and "hot" patients.

There were many things the nurses felt they could do to help themselves to cope better. Four of the respondents wanted to be able to confront their stressors more and four nurses spoke of attending stress management workshops. Other "helps" were: being more physically active; learning more about oncology; being able to talk more honestly about death with a dying patient; talking to someone about what was really bothering her; coming to work early to prepare herself for the day; becoming more aware of personal needs; getting less emotionally involved with patients; improving skills; keeping open communication with others; and getting more rest.

Five nurses could think of nothing that others could do to help them cope better. However, there were some definite ideas by the other nurses about what others could do: if own family/staff asked how she was doing; giving more feedback on her work; being more willing to listen; giving ideas on how to deal with dying patients and their families; giving help when the workload is heavy; stopping complaining; and more readily passing on information.

An important trend in this area of what could help the nurses to cope more effectively with their stress seems to be a combination of communication, emotional support, physical aspects and information. The hospital in the sample already provides much in the way of support and help for the nurses, but the need to talk, be listened to and share feelings seems very intrinsic to many of the "helps" the nurses mentioned.

Physical aspects (more staff, a nurses' lounge, fitness programs, being physically active, rotation through other departments) are also important factors to be considered. Also, the informational needs (learning more, improving skills, getting ideas from others) were apparent, though to a lesser degree.

Demographic differences

Due to the nature of this enquiry, and the fact that each subject differs from the others, it is difficult to make any demographic comparisons. Larger samples would make such comparisons easier and perhaps more valid. There are some differences among the subjects that can be attributed to demographic factors, but their significance is somewhat negligible.

In comparing part time and full time staff, the main difference was in the coping strategy of working part time. By working part time, those nurses were subject to less stress and had more time to deal with their stress outside of work.

From the list of specific strategies, only three of the seven full time staff used strategy 8 (Prepare yourself to expect the worst) as compared to six of the seven part time staff. However, it is uncertain what meaning, if any, this difference might have.

For newer staff (3 to 12 months), the stress related to the newness of their jobs was mentioned, though this stress seemed to lessen the more familiar they become with their jobs. Many of the respondents commented on their first weeks on the job as being extremely stressful due to the orientation, the amount of new knowledge, new experiences and, for some, the increased exposure to death.

To get a better understanding of possible demographic differences, based on working full time vs. part time, years of nursing experience and time as a ward nurse in this setting, a larger sample is needed to give more information from which specific conclusions may be drawn. Another demographic variable that might be considered is age; life experience may be a factor in coping strategies that individuals use. However, there is not enough information in this study to make such conclusions.

Perceptions of coping with stress

In the initial part of the interview, the respondents were asked what coping with stress meant to them, to help them begin to think in terms of coping with stress and to be better able to answer the questions that followed. However, some interesting ideas on the perception of coping came out of this.

Lazarus and Launier (1978) discuss the function of coping as being instrumental (affecting the stressed person-environment transaction) or palliative (controlling the emotional reaction). Eight of the respondents had an instrumental focus to their meaning of coping with stress, three had a palliative focus, and three could be interpreted as having an instrumental or palliative focus. All of the respondents seemed to use both instrumental and palliative strategies when coping with stressful situations, despite how they defined it. It is difficult to determine from these results how a person's view of coping with stress (whether instrumental or palliative) influences their coping strategies (if at all). Other factors such as the stressor, the environment, perceived stress, etc. need to be considered when a coping strategy is chosen. However, if a person is more one than the other (instrumental or palliative) in their coping, it may provide areas for training of coping strategies;

i.e. if someone is more instrumentally oriented, they may be taught some palliative strategies to improve upon their coping ability.

Individual's perceptions of what coping with stress means likely influences how they cope. A specific perspective can affect coping strategies, attitudes and expectations of effectiveness. However, it is uncertain how the meaning attributed to coping by the respondents in this study affected their coping. To determine an effect, more knowledge of their coping behaviors would be needed over a period of time and likely require observational, as well as self report, data.

Conclusion

Although this study is exploratory in nature and limited, due to the small sample studied, there are some important conclusions that can be drawn from the trends and themes that have emerged. The common theme of support, especially from nursing peers, is strong throughout the discussion, as is the need for more or continued support from other areas (family, support services). Also, a wide variety of strategies and resources were used, linked with a general overall response of good "felt" effectiveness in coping with stress. Awareness of areas of difficulty in coping seemed to promote a desire for more information and ideas so that this difficulty could be eased.

The importance of colleague support emerged from the coping strategies and coping resources that were discussed by the respondents. The support from other sources was also valuable, but often the respondents commented that it was a situation or feeling only one of their co-workers could understand. The current work setting supplies much in the way of needed support systems for the nurses, but the need for more opportunity to get support, express feelings and gain new ideas and insights by meeting with others (other nurses, psychologists) was expressed numerous times.

A wide variety of strategies and resources were used by all of the respondents, with many similarities and some interesting personal differences. It has been found that the broader the repertoire of coping strategies, the more effectively the individual will likely cope with his/her stress (Sidle et al, 1969; Jacobson, 1976; Pearlin and Schooler, 1978).

However, for some of the respondents, there was dissatisfaction with their coping effectiveness in specific situations. This was often due to either a lack of coping strategies in that area or a lack of application of known strategies. Some of the respondents found it helpful to consider how they coped with stress by participating in the interview, as it clarified for them what they did and perhaps some changes they needed to make to cope more effectively. Other subjects, who were satisfied with how they coped, were still interested in learning more strategies.

How these nurses cope with stress they encounter working in an oncology setting illustrates the many similarities and differences in coping behavior. That which helps them cope is important to be aware of as this information may help others in similar settings cope with stress. Those areas where there was difficulty in coping with stress and that which may help them to cope better need to be considered as well in attempting to improve how individuals cope with stress.

Implications and Recommendations for the Setting and the Sample

How stress is coped with is an important question for the nursing profession, particularly in an identified high stress setting such as oncology nursing. First, the hospital under study should be commended for the programs and support it continues to provide for the nursing staff. It was felt to have a supportive and helpful environment by the respondents in general.

Through the respondent's comments on the hospital environment, their needs and their stress indicators, the following suggestions are summarized options for preventing and managing stress in the oncology setting.

1. group meetings: Gray-Toft (1980), in her exploratory study, found ongoing group support provided her sample of hospice nurses with an arena to: develop greater self awareness of their reactions to work stress and awareness of the effect on them of stress outside the hospital; express and accept feelings related to stress; understand the dying patient and family and the physician; and develop communication skills and group support. It was found that this type of program contributed to a "... significant reduction in the frequency of stress associated with death and dying and workload ... a significant increase in satisfaction with co-workers ... [and] may have been instrumental in reducing staff turnover" (Gray-Toft, 1980, p. 352). In short, this progam was felt to help the nurses to cope better with their stress. Such a program could be considered for the setting in this study.

2. inservices: Workshops on stress and coping were felt to be helpful, but not offered frequently enough. As well, the expressed difficulties in coping with: death and dying, communication problems and families of dying patients are indications of further educational needs in the psychosocial aspects of nursing.

3. individual opportunities for counselling: The need for nurses to talk about their feelings, what stresses them and how they were coping was quite evident in the interviews. Being able to share these things with the interviewer was felt to be a helpful experience by some. Many of the nurses spoke of wanting more contact with the psychologists on staff. They also need to be aware that they can make direct contact with the psychologists and, that it is not only acceptable, but encouraged.

4. more staff: Though many of the respondents felt the hospital was better staffed than many other hospitals, they felt more nursing staff was needed due to the demanding nature of the quality of nursing required. They also requested more staff be available so workshops and inservices could be more easily attended.

5. staff support: The support the staff give to one another seems to be a key factor in helping the nurses to cope with many different stressful situations. This type of support should be encouraged and fostered in some way. Patrick (1981) stated that support needs to be built into the health care system as a highly stressed nurse may not seek support. Or as in the case of Subject H, her relative newness and variable rotation kept her from feeling connected with the other staff, although she found them supportive. By having the support from the other staff more structured, staff like H may be helped to feel more connection and support.

6. nurses' lounge, fitness programs at different times, rotations through other departments: These were other areas suggested where the hospital might help.

Although additional programs and staffing are usually subject to budget restraints in the hospital setting, a cost benefit analysis could yield information as to the possible potential. Less burnout, less stress related illness and time off, more job satisfaction, and more effective, quality nursing care are all open to inquiry.

Where the individual nurse may be able to help herself/himself more is with insight into her/his own needs and acknowledgement of her/his limitations. The identification of that which blocks one from coping and that which helps one with coping seems to be very important; the identifiable is often more easily dealt with than the unknown. Without this insight and acknowledgement, the stress may be less easily coped with and eventually lead to burnout.

Some additional recommendations are apparent when the described stress indicators are considered. The purpose of having the respondents describe their stress indicators was to help them focus on what stress was for them so that they might better describe how they coped. By being specific about their stressors, they seemed to be able to be specific about coping and coping effectiveness. However, these indicators suggested the need for other specific interventions that might help the nurses to cope better with their stress:

1. relaxation training: The physiological indicators such as headaches, diarrhea, muscle tension, insomnia, etc. could be reduced through relaxation training, especially when the stress is from an unchangeable source.

2. desensitization or stress inoculation: The emotional reactions to stress, such as tearfulness, irritability, lack of patience, etc., may be reduced by preparing the nurses for the stress they might encounter, so that it has potentially less impact upon them. This would also affect the physiological indicators.

3. self awareness workshops: Often, by the time an individual

feels stress reactions such as headaches, insomnia, depression, chainsmoking, increased alcohol comsumption, etc., they have difficulty dealing with the stress indicators. By being more aware of their body and its reactions to stress, they may be able to intervene or cope with the stress before they have a serious stress reaction.

4. coping strategy awareness: There was some concern expressed about healthy vs. less healthy forms of coping. Increased alcohol consumption, chainsmoking, increased appetite, etc. are stress indicators, but are also forms of coping with stress that can lead to health problems. Individuals using such strategies could benefit by being made more aware of healthier coping alternatives others use with success.

5. assertiveness training: Some of the stress indicators occurred in situations of confrontation with others (patient's family, physicians). This may indicate a need for assertiveness training to help some of the nurses cope with the stress of such situations.

Implications for Helping Professionals Working in an Oncology Setting

Though the subjects studied are a limited sample from a very specific setting, there are implications for other nurses and other helping professionals in similar work settings. The basic strategies and resources used by the nurses in this study are not restricted to nurses, but are used by everyone in coping with stress. Different individuals who work in oncological or palliative care settings may use this information from this study to evaluate and come to terms with their own coping strategies, coping resources and coping effectiveness with stress. Those awarenesses may lead to reinforcement of current coping behaviors they use and/or re-evaluation of how to cope better with stress. Also, the needs identified by the nurses from those things that may block or help coping may assist in defining for other helping professionals what is helping or blocking them in the coping process and what they need to do for themselves to improve their effectiveness.

Implications for Further Research

Due to the descriptive nature of this study, the results and subsequent discussion are of themes, trends and generalities. However, this type of research is important in laying the groundwork for studies more empirical in nature. The following are suggestions for further research:

1. Use of other data gathering procedures: This study utilized the interview procedure for describing, measuring and evaluating coping. The value of other types of procedures and the differences in the information gained needs to be explored.

2. Use of a larger sample: Because the conclusions from this study cannot be generalized much beyond the specific setting and sample, it would be useful to see the results comparing the demographic variables with a larger sample.

3. Use of other populations: Another area of study would be to compare the coping strategies, coping resources and coping effectiveness with stress of different helping professionals in similar areas to determine what differences there are among helping professionals.

4. Investigate appraisal: Exploration of the appraisal process (primary and secondary) and its relationship to coping strategies is needed.

5. Unconscious coping mechanisms: Unconscious coping mechanisms

were not investigated in this study and yet, likely have much impact on how an individual copes. What the impact and effectiveness are of these types of strategies needs to be determined.

6. Exploration of self awareness as a coping resource: As was proposed in the discussion, more research is needed to determine whether or not self awareness could be a coping resource or is just a component of the coping resources already identified by Folkman et al (1979).

7. Development of and capacity for change in coping strategies: How coping strategies develop, especially effective and ineffective patterns, and how they change is another area for investigation. (Roskies and Lazarus, 1979).

8. Explore the impact of personal and societal factors on job related stress: We do not work in isolation, but are influenced by our personal lives and societal factors. Just how these areas affect how we cope with stress, in our jobs and elsewhere, was not considered in this study, but likely has tremendous influence on the coping process and needs to be researched.

9. Locus of control: Research is needed on the impact of locus of control on an individual's ability to cope with stress.

10. Personal motivation: One's motivation for working in an oncology setting may influence coping strategies, resources and effectiveness.

11. Early resignation: There may be a difference in the coping resources, strategies and effectiveness of nurses who leave the oncology work setting prior to six months of work compared with those who remain for longer than six months. If such a difference were to be found, this may have impact on nursing education, hiring practices and inservices offered in the oncology setting.

Hypotheses could be developed for many of the above suggestions. Much research is needed in the area of coping so that it may be more clearly understood.

Delimitations

There are a number of methodological problems with this study. A brief discussion of these problems is needed.

The subjects were taken from one setting, thereby limiting the generalizability of the findings. To help this problem, subjects would need to be taken from a variety of oncology treatment settings to control for any secondary variation that may be as a result of the use of one setting and to be able to apply the results to a larger population.

In the analysis of the results, demographic variables were to be considered. Due to the limited number of subjects, this was a difficult task and the findings were not relevant. A larger sample may yield more definite demographic differences.

The self report method of gathering data has its problems. The respondents found talking hypothetically difficult. Coping strategies and resultant effectiveness recalled from previous experiences may have been altered from the actual facts due to the amount of intervening time and the possible influence of defense mechanisms. Weinstein, Averill, Opton and Lazarus (1968) found a lack of agreement between physiological measures and self report measures of stress; this may also be found to be true when assessing coping. This may support the use of a multi-faceted research method (comparing self report measures with physiological and psychological measures), despite its complexity, to get a more accurate picture of coping.

The methodological problems need to be kept in mind when reviewing the results and considering future research.

SELECTED REFERENCES

Alker, H.A. Coping, defenses and socially desirable responses. Psychological Reports, 1968, 22: 985-988.

Andreasen, N.J.C.; Noyes, Russell Jr.; & Hartford, C.E. Adjustment of burn patients during hospitalization. In Alan Monat and R.S. Lazarus (Eds.), Stress and Coping: An anthology. New York: Columbia University Press, 1977.

Antonovsky, A. Health, stress and coping. San Francisco: Jossey-Bass Publishers, 1979.

Appley, M.H. & Trumbull, Richard. On the concept of psychological stress. In M.H. Appley and Richard Trumbull (Eds.), Psychological stress: Issues in research. New York: Appleton-Century-Crofts, 1967.

Arcand, Rhea. Stress for nurses working with the cancer patient. Master's thesis, University of Alberta, 1980.

Bandura, A. Self efficacy: Toward a unifying theory of behavioral change. Psychological Review, 1977, 84: 191-215.

Berkman, L. Social networks, host resistance and mortality: a follow-up study of Almeda County residents. Unpublished doctoral dissertation, University of California, Berkeley, 1977.

Beszterczey, Akos. Staff stress on newly developed palliative care service: The psychiatrist's role. Canadian Psychiatric Association Journal, 1977 (Nov), 22(7): 347-353.

Borg, Walter R. & Gall, Meredith, D. Educational Research: An Introduction (2nd edition). New York: David McKay Co. Inc., 1971.

Coelho, G.V.; Hamburg, D.A.; & Murphy, Elizabeth B. Coping strategies in a new learning environment. Archives of General Psychiatry, 1963, 9: 433-443.

Davitz, L.J. & Davitz, J.R. How do nurses feel when patients suffer? American Journal of Nursing, 1975, 75 (3): 1505-1510.

Edwards, Glen M. The relationship between meaning and crisis: A case study approach. Master's thesis, University of Alberta, 1982.

Folkman, S.; Schaefer, C.; & Lazarus, R.S. Cognitive processes as mediators of stress and coping. In V. Hamilton and D.M. Warburton (Eds.), Human stress and cognition: An information processing approach. London: Wiley, 1979.

Folta, J.R. Nurses' perceptions of role requirements and role action in situations involving death in hospitals. Unpublished doctoral dissertation, University of Washington (Seattle), 1963.

Gluck, Miriam. Overcoming stress in communication with the fatally ill. Military Medicine, 1977 (Dec.), 142 (12): 926-928.

Goldstein, M.J. Individual differences in response to stress. American Journal of Community Psychology, 1973, 2: 113-137.

Gore, Susan. Does help-seeking increase psychological distress? Journal of Health and Social Behavior, 1979 (Jun), 20 (2): 201-202.

Gow, C.M. & Williams, J.I. Nurse's attitude toward death and dying: A casual interpretation. Social Science and Medicine, 1977, 11: 191-198.

Gray-Toft, Pamela. Effectiveness of a counselling support program for hospice nurses. Journal of Counselling Psychology, 1980 (Jul), 27(4): 346-354.

Guba, Egon. Naturalistic inquiry. Improving Human Performance Quarterly, 1979, 8: 268-276.

Hamburg, D.A. & Adams, J.E. A perspective on coping: Seeking and utilizing information in major transitions. Archives of General Psychiatry, 1967, 17: 277-284.

Hamburg, D.A.; Coelho, George V.; & Adams, John E. Coping and adaptation: Steps toward a synthesis of biological and social perspectives. In G.V. Coelho, D.A. Hamburg and J.E. Adams (Eds.), Coping and Adaptation. New York: Basic Books, 1974.

Hartl, D.E. Stress management and the nurse. Advances in Nursing Science, 1979, 1(4): 91-100.

Hay, Donald & Oken, Donald. The psychological stresses of intensive care unit nursing. In Alan Monat and R.S. Lazarus (Eds.), Stress and coping: An anthology. New York: Columbia University Press, 1977.

Huckabay, L.M.D. & Jagla, B. Nurses' stress factors in the intensive care unit. Journal of Nursing Administration, 1979 (Feb), 9(2): 21-26.

Jacobson, Sharon F.P. Stresses and coping strategies of neonatal intensive care unit nurses. Doctoral dissertation, University of Minnesota, 1976.

Jevne, Ronna. Counsellor competencies and selected issues for Canadian counsellor education. Doctoral dissertation, University of Calgary, 1978.

Katz, J.L.; Weiner, H.; Gallagher, T.G.; & Hellman, L. Stress, distress and ego defenses, Archives of General Psychiatry, 1970, 23: 131-142.

Kerlinger, F. Foundations of behavioral research. New York: Holt, Rinehart and Winston, Inc., 1965.

Klagsbrun, S.C. Cancer, emotion and nurses. American Journal of Psychiatry, 1970, 126(9): 1237-1244.

Kleinmutz, B. The interview in personality measurement: An introduction. Homewood, Illinois: Dorsey, 1967.

Lazarus, R.S. A cognitively oriented psychologist looks at biofeedback. American Psychologist, 1975, 30: 553-561.

__________. Psychological stress and coping in adaptation and illness. International Journal of Psychiatry in Medicine, 1974, 5: 321-333.

__________. Psychological stress and the coping process. New York: McGraw-Hill, 1966.

Lazarus, R.S.; Averill, J.R.; & Opton, E.M. Jr. The psychology of coping: Issues of research and assessment. In G.V. Coelho, D.A. Hamburg and J.E. Adams (Eds.), Coping and adaptation. New York: Basic Books, 1974.

Lazarus, R.S. & Launier, R. Stress related transactions between person and environment. In L.A. Pervin and M. Lewis (Eds.), Perspectives in interactional psychology. New York: Plenum Press, 1978.

Lefcourt, H. Locus of control and the acceptance of one's reinforcement experience. Colloquia, 1974.

Lester, David; Getty, Cathleen; & Kneisl, Carol. Attitudes of nursing students and nursing faculty toward death. Nursing Research, 1974, 23: 50-53.

Mason, J.W. A historical view of the stress field. Journal of Human Stress, 1975, 1(2): 22-37.

Michaels, D.R. Too much in need of support to give any? American Journal of Nursing, 1971, 71(10): 1932-1935.

Monat, Alan & Lazarus, R.S. Stress and coping - some current issues and controversies. In Alan Monat and R.S. Lazarus (Eds.), Stress and coping: An anthology. New York: Columbia University Press, 1977.

Patrick, Pamela K.S. Burnout antecedents, manifestations and self care strategies for the nurse. In Lisa Begg Marino (Ed.), Cancer Nursing. Toronto: C.V. Mosby Co., 1981.

Pearlin, L.I. & Schooler, C. The structure of coping. Journal of Health and Social Behavior, 1978, 19: 2-21.

____________. Some extensions of "The structure of coping": Reply to comments by Marshall and Gore. Journal of Health and Social Behavior, 1979, 20(2): 202-205.

Quint, J.C. Awareness of death and nurse's composure. Nursing Research, 1966 (Winter), 15: 49-55.

Richardson, Stephen A.; Dohrenwend, Barbara S.; & Klein, David. Interviewing: Its forms and functions. New York: Basic Books, 1965.

Roskies, Ethel & Lazarus, R.S. Coping theory and teaching of coping skills. In Park O. Davidson and Sheena M. Davidson (Eds.), Behavioral medicine: Changing health lifestyles. New York: Brunner/Mazel, 1979.

Sidle, A.; Moos, R.; Adams, J.; & Cody, P. Development of a coping scale. Archives of General Psychiatry. 1969, 20: 225-232.

Sonstegaard, L.; Hansen, N.; Zellman, L.; & Johnston, M.K. The grieving nurse. Journal of Nursing, 1976, 76(9): 1490-1492.

Stoller, E.P. Effect of experience on nurses' responses to dying and death in the hospital setting. Nursing Research, 1980, 29(1): 35-38.

Vachon, M.L.S. Motivation and stress experienced by staff working with the terminally ill. Death Education, 1978, 2 (1-2): 113-122.

Weinstein, Joshua; Averill, James A.; Opton, E.M. Jr.; & Lazarus, R.S. Defensive style and discrepancy between self report and physiological indices of stress. Journal of Personality and Social Psychology, 1968, 10: 406-413.

Weisman, A.D. & Worden, J.W. The existential plight in cancer: Significance of the first 100 days. International Journal of Psychiatry in Medicine, 1976-77, 7: 1-15.

White, Robert W. Strategies of adaptation: An attempt of systematic description. In G.V. Coelho, D.A. Hamburg and J.E. Adams (Eds.), Coping and Adaptation. New York: Basic Books, 1974.

Wilson, Janet. Perspectives on motherhood: A phenomenological study of women's transition to motherhood. Master's thesis, University of Alberta, 1982.

APPENDIX A

PRESENTATION TO THE NURSES

My name is Mary Molyneux and I am a graduate student in the department of Educational Psychology at the university. As some of you know, a study was done here a couple of years ago by Rhea Arcand on the stress that nurses encounter working in an oncology setting. Sources of stress were identified by Ms. Arcand in that study. A natural sequel to such research is to explore how nurses cope with such stressors.

This type of information can assist in the following ways:

1.) Help nurses in assessing their stress level, how they cope and their coping effectiveness. This may help provide an early warning system for evaluating burnout.

2.) Assist nurses in developing alternative coping possibilities.

3.) Assist nurses in being aware of their coping resources and how they use them.

4.) Help nurses to be aware of what may be blocking them from coping effectively and what might help them to cope better.

The participants will be involved in a tape recorded interview, approximately one to one and a half hours in length. I am handing out information sheets for you to complete to give me some demographic data and for you to indicate whether or not you are willing to participate. If you choose not to participate at this time, I would appreciate it if you would share your rationale with me by jotting it down at the bottom of the page. That would be valuable information for me and as with any other information I get, will be strictly confidential. Are there any questions? Could you fill out these sheets and I will gather them in in a few minutes?

Thank you for your attention and cooperation. I'm going to be talking with other ward nurses and, once I have all the information sheets, I will randomly select five nurses for the pilot part of the project to help validate my interview process. Then fourteen more nurses will be chosen to take part in the actual study. If you are not chosen for the pilot or the actual study, I appreciate your interest and want to let you know that the selection is random and does not reflect on you personally. Thank you again. Any questions?

APPENDIX B

INFORMATION SHEET

Name ______________________________

Home phone number ______________

Best times to call ______________________

Employed: Full time ___ Part time ___ (check one)

Number of years of nursing experience

0 to 1 years ___ 1 to 5 years ___ 5+ years ___ (check one)

Length of time as a ward nurse at the Cross Cancer Institute

0 to 3 months ___ 3 to 12 months ___ 13 to 24 months ___

25+ months ___ (check one)

Please check one of the following:

____ will participate

____ will not participate

If you have checked the second response, my study will be more valid if you would indicate your reasons. Any and all information that I receive will be kept confidential.

____

____

____

APPENDIX C

STRESSFUL INCIDENTS GENERATED

______________________________:

Here are the directions for generating the incidents/anecdotes. I hope they are clear; if they're not or if you run into some difficulties, please feel free to call me at . I really appreciate your help and efforts and am looking forward to seeing the stressful incidents you generate.

Thanks again!

____

In her 1980 study, Arcand identified two primary stressors and three secondary stressors for the nurses working at the Cross Cancer Institute. These stressors are: 1.) death/loss of a patient; 2.) dying and suffering of patients; 3.) job ambiguity; 4.) communication with the patient, the families, the team, physicians, and other nurses; and 5.) critical physician feedback.

Please generate three stressful incidents, that could be encountered by the nurses on the wards, for each stressor. What is meant by stressful is that the nurse may have felt nervous, fearful, tired, rushed, anxious, sad, confused, angry, tense, tearful, excited, etc. or any combination of these, due to the situation. Try to develop the situations that you feel best illustrate each stressor.

Please try to keep each situation specific to one stressor, so as to avoid contamination from another stressor. For example: A patient has just died, so the physician begins to criticize the nurse; this combines the stresses of the death of a patient with critical physician feedback, which is not wanted.

Because of your background and knowledge, you are more capable than I am of generating these stresful incidents. These incidents do not have to be long - just long enough to illustrate the stressor clearly. Also, try to be as specific as possible, e.g. "The doctor yelled at the nurse" is too general.

...2

Please write the incidents in the first person. Using "I" will hopefully personalize the incidents for the nurses and have more impact on them.

After you have generated the fifteen incidents (three for each of the five stressors), two other senior nursing staff will look over the incidents and pick the two most stressful incidents out of each set of three. This attempts to give the situations some validity.

A sample of situations generated by Jacobson (1976) is attached. Jacobson's (1976) study looked at neonatal ICU nurses and their stresses and coping skills; the attached sample of stressful situations is to give you some idea of what I am looking for.

Thank you again for your help and cooperation in generating these incidents. If you have any questions or concerns about this, please contact me at .

One of the purposes of this study is to determine what coping strategies the nurses use when dealing with stress. Five sources of stress for nurses working in an oncology setting have been identified by Arcand (1980): 1.) death/loss of a patient; 2.) dying and suffering of patients; 3.) job ambiguity; 4.) communication with patients, the families, the team, physicians and other nurses; and 5.) critical physician feedback. Incidents have been generated, that could be encountered by the nurses on the wards, for each stressor. These incidents were to be stressful (i.e. could cause the nurses to feel nervous, tired, fearful, rushed, anxious, sad, confused, angry, tearful, tense, excited, etc. or any combination of these); specific to each stressor so as to avoid contamination from the other stressors; and clear and realistic.

Please confer and choose those incidents (two per source of stress) that best meet those criteria and would be most stressful. Once you have chosen these incidents, they will be presented to the nurses with questions to try to discover what strategies they use to cope with the stress.

Thank you for your help. If you have any questions, please feel free to contact me at .

Stressful Situations Selected

Death/loss of a patient:

Bob, an athletic, robust fellow of 21, was diagnosed as having metastatic cancer, primary unknown on a Friday. On the following Tuesday, he was admitted to our ward from another hospital. He appeared weak, pale and extremely ill, but was fully conscious. He commenced chemotherapy immediately but deteriorated rapidly. He talked about the fact that he may be dying but stated that he desperately wanted more time to prepare himself spiritually. On Thursday morning, he became very short of breath, needed to be intubated and bagged, was bleeding extensively, and was transferred to Intensive Care in another hospital where he died approximately thirty minutes later.

Dying and suffering:

My patient, Mrs. Y, was tiny and emaciated. She had been ill for a long time, had extensive disease and was suffering a great deal of pain. We were giving her very high doses of analgesics to try and keep her comfortable, but her pain was not well controlled. Every time I went to give her her analgesics, she said to me: "Lord Jesus, please take me this time, I am ready. Why don't I die?"

Job ambiguity:

I am looking after a patient from up north who is crying, very lonely and depressed. I know I should spend some time with her as she needs my support, but I also have three other patients receiving I.V. chemotherapy, have to assist with a bone marrow aspiration and have a patient to prepare for the O.R. I don't know what to do.

Communication with the patient, the families, the team, physicians and other nurses:

My patient has extensive cancer of the vulva and throughout the day, has had a progressively more difficult time voiding. By late afternoon, she can no longer void. Her family, of which there are many, have been with her continually and appear to glare at me each time I come into the room. I have not been able to break their cold reserve. I receive an order to catheterize the patient. When I advise the son of what I will be doing, he says: "It's about time!" After several tries, I cannot pass the catheter due to tumor invasion. When I inform the son that the physician must be called, he tells me I am incompetent and should not be allowed to nurse his mom and that he will advise the doctor of the same.

Critical physician feedback:

A patient's attending physician approaches me and angrily asks why I did not notify him last night of his patient's deteriorating condition. It was my understanding that he was aware. When I advised him of this, he states: "With you nurses, the right hand does not know what the left hand is doing! It seeems I can't trust my patients in your care anymore!"

APPENDIX D

LIST OF COPING STRATEGIES

The following is a list of strategies that will be used in this study. Because Sidle et al (1969) found that the ten strategies they derived were relatively independent ways of coping, all ten of those strategies will be used; however, Sidle's strategy 3 (Try to see the humorous aspects of the situation) is considered to be part of his strategy 10 (Try to reduce tension). Strategies 9 (Look for ways to keep perspective), 11 (Search for philosophical and spiritual meaning), 12 (Cultivate an objective, intellectual attitude) and 13 (Rework the situation in your imagination) from Jacobson (1976) were also chosen. Strategies 9, 11, and 13 were chosen as they were not covered by Sidle and have potential as coping strategies. Strategy 12 was chosen as it is a finer derivation of Sidle's strategies 5 (Become involved in other activities in order to keep your mind off the problem) and 6 (Take some positive concerted action based on your present understanding of the situation) and is frequently mentioned in the literature as a way that nurses cope. Sidle et al's (1969) and Jacobson's (1976) lists are found in their entirety in the literature review. The wording of the following strategies may differ to some extent from the originals, but they are intended to impart the same strategies. Strategies 1 through 10 are derived from Sidle's list; strategies 11 through 14 are from Jacobson's list.

1.) Seek more information about the situation.

2.) Talk with friends or relatives about the situation.

3.) Talk with other professionals about the situation. (The division of talking with friends or relatives from talking with other professionals was recommended by Jacobson(1976) as she felt they represented two different coping strategies; this author agrees.)

4.) Don't worry about it; what is done is done.

5.) Do something else to take your mind off what has happened.

6.) Try to reduce your tension.

7.) Develop different ways to deal with the situation.

8.) Prepare yourself to expect the worst.

9.) Take some positive concerted action based upon your present understanding of the situation.

10.) Recall past experiences to see how you dealt with similar situations.

11.) Use your imagination and go through the situation again.

12.) Look for ways to keep your perspective on the situation.

13.) Search for philosophical and spiritual meaning to your experience.

14.) Remain cool and objective.

APPENDIX E

INTERVIEW FORMAT

I am doing an exploratory study in the area of coping with stress. Studies have indicated that nursing can be stressful; some studies indicate particularly oncology nursing. Considerable investigation has been done on stress, but little is known about the nature and quality of coping with stress. By discussing these areas with you and finding out the nature and level of how you cope - which may be on a continuum from coping well to needing some new ideas on how to cope - I hope to gain more insight into the process of coping. If you have any questions, please feel free to ask them. Anything you say will be kept strictly confidential, however, quotes may be used from the interviews in the analysis of the information in my thesis.

Confirmation of demographic data.
What led you to become a nurse? Where did you train?

What does the term stress mean to you?
How do you know when you are experiencing stress? What indicators do you have or what things change in you life when under stress? Any changes in your relationship with others, any physical or emotional indicators? Any disturbances in sleeping or eating patterns?
What does coping with stress mean to you?
When you experience some change in your life from stress, what do you do to reduce the stress or deal with it? Can you name some specific things you do that help you to cope with stress?
How do you know when you have coped effectively with stress?
What do you feel or encounter that indicates to you that you have coped effectively?

I am going to show you five different situations that were generated by some staff members here at the Cross. These were to be stressful situations a ward nurse might encounter at the Cross. I am going to have you read one situation at a time and then we will talk about it; we will go through all five situations in that way. Although these situations were verified as stressful, you may not find one or any of them stressful and you may not have encountered anything like them. If you have any questions while we are talking, please feel free to ask them.

Is that a situation that you would find stressful or can you recall an experience similar to this one? (If no, I would be interested in hearing why you don't find it stressful.)
Tell me about the stress you would feel in this situation or felt in the similar situation.
How did you deal with the stressful feelings? How effective would your coping be? How do you feel about coping in this way?

(Repeat for all five situations.)

Is there anything: a.) the institution; b.) yourself; c.) others do that block you from coping better with job related stress? (Each of these areas was asked as a separate question.)
How well did the Cross prepare you to deal with the situations you encounter?
Is there anything: a.) the institution; b.) yourself; c.) others could do that would help you to cope better with job related stress? (Each of these areas was asked as a separate question.)
Can you identify the resources you use that help you to cope with the

stress you encounter on your job?

How effectively overall do you feel you cope with stress?

Do you feel you have enough strategies for coping with stress?

I am going to read to you a list of coping strategies. These are just different ways of dealing with stress and one is not necessarily better than the other. After I read one and give you an example of it, I would like you to tell me if it is something you use frequently, sometimes or not at all in dealing with job related stress. You may or may not have used some of these strategies; these may be different from what you do.

1.) Seek more information about the situation. (read articles, go to inservices, attend workshops)

2.) Talk with friends or relatives about the situation.

3.) Talk with other professionals about the situation. (other nurses, the psychologists, other staff)

4.) Don't worry about it; what is done is done.

5.) Do something else to take your mind off what has happened. (do other duties)

6.) Try to reduce your tension. (joke, eat or smoke more, exercise, drink, take tranquilizers)

7.) Develop different ways to deal with the situation.

8.) Prepare yourself to expect the worst. (maybe worry about a situation, expect a patient to die)

9.) Take some positive concerted action based on your present understanding of the situation. (do something for the patient or family)

10.) Recall past experiences to see how you have dealt with similar situations.

11.) Use your imagination and go through the situation again. (rework it in your mind)

12.) Look for ways to keep your perspective on the situation. (he's an old man, she's had a bad day, they are really worried and that's why they blew up at me, everyone has to die sometime)

13.) Search for philosophical and spiritual meaning to your experiences. (God has a plan, this is the way of the world)

14.) Remain cool and objective. (remove yourself emotionally from the situation and focus on the physical and clerical aspects of patient care)

Thank you very much for the time and effort you have given me. I really appreciate it. Do you have any feedback on the interview process or any comments or questions that you would like to ask?